

106TH CONGRESS  
2D SESSION

# S. 3077

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

SEPTEMBER 20, 2000

Mr. MOYNIHAN (for himself, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. BREAUX, Mr. GRAHAM, Mr. KERREY, Mr. ROBB, Mr. KENNEDY, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. EDWARDS, Mr. HOLLINGS, Mr. INOUE, Mr. JOHNSON, Mr. KERRY, Ms. LANDRIEU, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mr. MILLER, Mrs. MURRAY, Mr. REED, Mr. SARBANES, Mr. SCHUMER, Mr. TORRICELLI, and Mr. WELLSTONE) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECUR-**  
 2 **RITY ACT; REFERENCES TO OTHER ACTS;**  
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
 5 “Medicare, Medicaid, and SCHIP Balanced Budget Re-  
 6 finement Act of 2000”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-  
 8 cept as otherwise specifically provided, whenever in this  
 9 Act an amendment is expressed in terms of an amendment  
 10 to or repeal of a section or other provision, the reference  
 11 shall be considered to be made to that section or other  
 12 provision of the Social Security Act.

13 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

14 (1) **THE BALANCED BUDGET ACT OF 1997.**—  
 15 The term “BBA” means the Balanced Budget Act  
 16 of 1997 (Public Law 105–33; 111 Stat. 251).

17 (2) **THE MEDICARE, MEDICAID, AND SCHIP**  
 18 **BALANCED BUDGET REFINEMENT ACT OF 1999.**—  
 19 The term “BBRA” means the Medicare, Medicaid,  
 20 and SCHIP Balanced Budget Refinement Act of  
 21 1999 (113 Stat. 1501A–321), as enacted into law by  
 22 section 1000(a)(6) of Public Law 106–113.

23 (d) **TABLE OF CONTENTS.**—The table of contents of  
 24 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other Acts;  
 table of contents.

## TITLE I—PROVISIONS RELATING TO PART A

## Subtitle A—Skilled Nursing Facilities

- Sec. 101. Eliminating reduction in skilled nursing facility (SNF) market basket update.
- Sec. 102. Revision of BBRA increase for skilled nursing facilities in fiscal years 2001 and 2002.
- Sec. 103. MedPAC study on payment updates for skilled nursing facilities; authority of Secretary to make adjustments.

## Subtitle B—PPS Hospitals

- Sec. 111. Revision of reduction of indirect graduate medical education payments.
- Sec. 112. Eliminating reduction in PPS hospital payment update.
- Sec. 113. Eliminating reduction in disproportionate share hospital (DSH) payments.
- Sec. 114. Equalizing the threshold and updating payment formulas for disproportionate share hospitals.
- Sec. 115. Care for low-income patients.
- Sec. 116. Modification of payment rate for Puerto Rico hospitals.
- Sec. 117. MedPAC study on hospital area wage indexes.

## Subtitle C—PPS Exempt Hospitals

- Sec. 121. Treatment of certain cancer hospitals.
- Sec. 122. Payment adjustment for inpatient services in rehabilitation hospitals.

## Subtitle D—Hospice Care

- Sec. 131. Revision in payments for hospice care.

## Subtitle E—Other Provisions

- Sec. 141. Hospitals required to comply with bloodborne pathogens standard.
- Sec. 142. Informatics and data systems grant program.
- Sec. 143. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.

## Subtitle F—Transitional Provisions

- Sec. 151. Reclassification of certain counties and areas for purposes of reimbursement under the medicare program.
- Sec. 152. Calculation and application of wage index floor for a certain area.

## TITLE II—PROVISIONS RELATING TO PART B

## Subtitle A—Hospital Outpatient Services

- Sec. 201. Reduction of effective HOPD coinsurance rate to 20 percent by 2014.
- Sec. 202. Application of transitional corridor to certain hospitals that did not submit a 1996 cost report.
- Sec. 203. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by children's hospitals.

## Subtitle B—Provisions Relating to Physicians

- Sec. 211. Loan deferment for residents.

- Sec. 212. GAO studies and reports on medicare payments.
- Sec. 213. MedPAC study on the resource-based practice expense system.

#### Subtitle C—Ambulance Services

- Sec. 221. Election to forego phase-in of fee schedule for ambulance services.
- Sec. 222. Prudent layperson standard for emergency ambulance services.
- Sec. 223. Elimination of reduction in inflation adjustments for ambulance services.
- Sec. 224. Study and report on the costs of rural ambulance services.
- Sec. 225. Interim payments for rural ground ambulance services until regulation implemented.
- Sec. 226. GAO study and report on the costs of emergency and medical transportation services.

#### Subtitle D—Preventive Services

- Sec. 231. Elimination of deductibles and coinsurance for preventive benefits.
- Sec. 232. Counseling for cessation of tobacco use.
- Sec. 233. Coverage of glaucoma detection tests.
- Sec. 234. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.
- Sec. 235. Studies on preventive interventions in primary care for older Americans.
- Sec. 236. Institute of Medicine 5-year medicare prevention benefit study and report.
- Sec. 237. Fast-track consideration of prevention benefit legislation.

#### Subtitle E—Other Services

- Sec. 241. Revision of moratorium in caps for therapy services.
- Sec. 242. Revision of coverage of immunosuppressive drugs.
- Sec. 243. State accreditation of diabetes self-management training programs.
- Sec. 244. Elimination of reduction in payment amounts for durable medical equipment and oxygen and oxygen equipment.
- Sec. 245. Standards regarding payment for certain orthotics and prosthetics.
- Sec. 246. National limitation amount equal to 100 percent of national median for new pap smear technologies and other new clinical laboratory test technologies.
- Sec. 247. Increased medicare payments for certified nurse-midwife services.
- Sec. 248. Payment for administration of drugs.
- Sec. 249. MedPAC study on in-home infusion therapy nursing services.

### TITLE III—PROVISIONS RELATING TO PARTS A AND B

#### Subtitle A—Home Health Services

- Sec. 301. Elimination of 15 percent reduction in payment rates under the prospective payment system for home health services.
- Sec. 302. Exclusion of certain nonroutine medical supplies under the PPS for home health services.
- Sec. 303. Permitting home health patients with Alzheimer's disease or a related dementia to attend adult day-care.
- Sec. 304. Standards for home health branch offices.
- Sec. 305. Treatment of home health services provided in certain counties.

#### Subtitle B—Direct Graduate Medical Education

- Sec. 311. Not counting certain geriatric residents against graduate medical education limitations.
- Sec. 312. Program of payments to children's hospitals that operate graduate medical education programs.
- Sec. 313. Authority to include costs of training of clinical psychologists in payments to hospitals.
- Sec. 314. Treatment of certain newly established residency programs in computing medicare payments for the costs of medical education.

#### Subtitle C—Miscellaneous Provisions

- Sec. 321. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).

### TITLE IV—RURAL PROVIDER PROVISIONS

#### Subtitle A—Critical Access Hospitals

- Sec. 401. Payments to critical access hospitals for clinical diagnostic laboratory tests.
- Sec. 402. Revision of payment for professional services provided by a critical access hospital.
- Sec. 403. Permitting critical access hospitals to operate PPS exempt distinct part psychiatric and rehabilitation units.

#### Subtitle B—Medicare Dependent, Small Rural Hospital Program

- Sec. 411. Making the medicare dependent, small rural hospital program permanent.
- Sec. 412. Option to base eligibility for medicare dependent, small rural hospital program on discharges during any of the 3 most recent audited cost reporting periods.

#### Subtitle C—Sole Community Hospitals

- Sec. 421. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 422. Deeming a certain hospital as a sole community hospital.

#### Subtitle D—Other Rural Hospital Provisions

- Sec. 431. Exemption of hospital swing-bed program from the PPS for skilled nursing facilities.
- Sec. 432. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by rural hospitals.
- Sec. 433. Treatment of certain physician pathology services.

#### Subtitle E—Other Rural Provisions

- Sec. 441. Revision of bonus payments for services furnished in health professional shortage areas.
- Sec. 442. Provider-based rural health clinic cap exemption.
- Sec. 443. Payment for certain physician assistant services.
- Sec. 444. Bonus payments for rural home health agencies in 2001 and 2002.
- Sec. 445. Exclusion of clinical social worker services and services performed under a contract with a rural health clinic or federally qualified health center from the PPS for SNFs.

- Sec. 446. Coverage of marriage and family therapist services provided in rural health clinics.
- Sec. 447. Capital infrastructure revolving loan program.
- Sec. 448. Grants for upgrading data systems.
- Sec. 449. Relief for financially distressed rural hospitals.
- Sec. 450. Refinement of medicare reimbursement for telehealth services.
- Sec. 451. MedPAC study on low-volume, isolated rural health care providers.

#### TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

- Sec. 501. Restoring effective date of elections and changes of elections of Medicare+Choice plans.
- Sec. 502. Special Medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 503. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.
- Sec. 504. Allowing movement to 50:50 percent blend in 2002.
- Sec. 505. Delay from July to November 2000, in deadline for offering and withdrawing Medicare+Choice plans for 2001.
- Sec. 506. Amounts in medicare trust funds available for Secretary's share of Medicare+Choice education and enrollment-related costs.
- Sec. 507. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 508. Modification of payment rules for certain frail elderly medicare beneficiaries.

#### TITLE VI—PROVISIONS RELATING TO INDIVIDUALS WITH END- STAGE RENAL DISEASE

- Sec. 601. Update in renal dialysis composite rate.
- Sec. 602. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.
- Sec. 603. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.
- Sec. 604. Coverage of certain vascular access services for ESRD beneficiaries provided by ambulatory surgical centers.
- Sec. 605. Collection and analysis of information on the satisfaction of ESRD beneficiaries with the quality of and access to health care under the medicare program.

#### TITLE VII—ACCESS TO CARE IMPROVEMENTS THROUGH MEDICAID AND SCHIP

- Sec. 701. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 702. Transitional medical assistance.
- Sec. 703. Application of simplified SCHIP procedures under the medicaid program.
- Sec. 704. Presumptive eligibility.
- Sec. 705. Improvements to the maternal and child health services block grant.
- Sec. 706. Improving access to medicare cost-sharing assistance for low-income beneficiaries.
- Sec. 707. Breast and cervical cancer prevention and treatment.

#### TITLE VIII—OTHER PROVISIONS

Sec. 801. Appropriations for Ricky Ray Hemophilia Relief Fund.

Sec. 802. Increase in appropriations for special diabetes programs for children with type I diabetes and Indians.

Sec. 803. Demonstration grants to improve outreach, enrollment, and coordination of programs and services to homeless individuals and families.

Sec. 804. Protection of an HMO enrollee to receive continuing care at a facility selected by the enrollee.

Sec. 805. Grants to develop and establish real choice systems change initiatives.

# **TITLE I—PROVISIONS RELATING TO PART A Subtitle A—Skilled Nursing Facilities**

## **SEC. 101. ELIMINATING REDUCTION IN SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE.**

(a) ELIMINATION OF REDUCTION.—Section 1888(e)(4)(E)(ii) (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (I), by adding “and” at the end;

(2) by striking subclause (II); and

(3) by redesignating subclause (III) as subclause (II).

(b) SPECIAL RULE FOR PAYMENT FOR SKILLED NURSING FACILITY SERVICES FOR FISCAL YEAR 2001.—

Notwithstanding the amendments made by subsection (a), for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001,

1 the Federal per diem rate referred to in paragraph  
2 (4)(E)(ii) of such section—

3 (1) for the period beginning on October 1,  
4 2000, and ending on March 31, 2001, shall be the  
5 rate determined in accordance with subclause (II) of  
6 such paragraph as in effect on the day before the  
7 date of enactment of this Act; and

8 (2) for the period beginning on April 1, 2001,  
9 and ending on September 30, 2001, shall be the rate  
10 computed for fiscal year 2000 pursuant to subclause  
11 (I) of such paragraph increased by the skilled nurs-  
12 ing facility market basket percentage change for fis-  
13 cal year 2001 plus 1 percentage point.

14 **SEC. 102. REVISION OF BBRA INCREASE FOR SKILLED**  
15 **NURSING FACILITIES IN FISCAL YEARS 2001**  
16 **AND 2002.**

17 (a) REVISION.—Section 101(d) of BBRA (113 Stat.  
18 1501A–325) is amended—

19 (1) in paragraph (1)—

20 (A) by striking “4.0 percent for each such  
21 fiscal year” and inserting “the applicable per-  
22 cent (as defined in paragraph (3)) for each  
23 such fiscal year (or portion of such year)”; and

24 (2) by adding at the end the following new  
25 paragraph:



1           “(3) APPLICABLE PERCENT DEFINED.—For  
 2           purposes of this subsection, the term ‘applicable per-  
 3           cent’ means, with respect to services provided  
 4           during—

5                   “(A) the period beginning on October 1,  
 6                   2000, and ending on March 31, 2001, 4.0 per-  
 7                   cent;

8                   “(B) the period beginning on April 1,  
 9                   2001, and ending on September 30, 2001, 8.0  
 10                  percent; and

11                  “(C) fiscal year 2002, 6.0 percent.”.

12           (b) EFFECTIVE DATE.—The amendments made by  
 13           subsection (a) shall take effect as if included in the enact-  
 14           ment of section 101 of BBRA (113 Stat. 1501A–324).

15   **SEC. 103. MEDPAC STUDY ON PAYMENT UPDATES FOR**  
 16                   **SKILLED NURSING FACILITIES; AUTHORITY**  
 17                   **OF SECRETARY TO MAKE ADJUSTMENTS.**

18           (a) STUDY.—The Medicare Payment Advisory Com-  
 19           mission established under section 1805 of the Social Secu-  
 20           rity Act (42 U.S.C. 1395b–6) (in this section referred to  
 21           as “MedPAC”) shall conduct a study of nursing home  
 22           costs to determine the adequacy of payment rates (includ-  
 23           ing updates to such rates) under the medicare program  
 24           under title XVIII of such Act (42 U.S.C. 1395 et seq.)  
 25           (in this section referred to as the “medicare program”)

1 for items and services furnished by skilled nursing facili-  
2 ties. In conducting such study, MedPAC shall use data  
3 on actual costs and cost increases.

4 (b) REPORT.—Not later than 12 months after the  
5 date of enactment of this Act, MedPAC shall submit a  
6 report to the Secretary of Health and Human Services and  
7 Congress on the study conducted under subsection (a), in-  
8 cluding a description of the methodology and calculations  
9 used by the Health Care Financing Administration to es-  
10 tablish the original payment level under the prospective  
11 payment system for skilled nursing facility services under  
12 section 1888(e) of the Social Security Act (42 U.S.C.  
13 1395yy(e)) and to annually update payments under the  
14 medicare program for items and services furnished by  
15 skilled nursing facilities, together with recommendations  
16 regarding methods to ensure that all input variables, in-  
17 cluding the labor costs, the intensity of services, and the  
18 changes in science and technology that are specific to such  
19 facilities, are adequately accounted for.

20 (c) AUTHORITY OF SECRETARY TO MAKE ADJUST-  
21 MENTS.—Notwithstanding any other provision of law, the  
22 Secretary of Health and Human Services may make ad-  
23 justments to payments under the prospective payment sys-  
24 tem under section 1888(e) of the Social Security Act (42  
25 U.S.C. 1395yy(e)) for covered skilled nursing facility serv-

ices to reflect any necessary adjustments to such payments  
as is appropriate as a result of the study conducted under  
subsection (a).

(d) PUBLICATION.—

(1) IN GENERAL.—Not later than April 1,  
2002, the Secretary of Health and Human Services  
shall publish for public comment a description of—

(A) whether the Secretary will make any  
adjustments pursuant to subsection (c); and

(B) if so, the form of such adjustments.

(2) FINAL FORM.—Not later than August 1,  
2002, the Secretary of Health and Human Services  
shall publish the description described in paragraph  
(1) in final form.

## **Subtitle B—PPS Hospitals**

### **SEC. 111. REVISION OF REDUCTION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.**

(a) REVISION.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii)  
(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) in subclause (IV), by adding “and” at  
the end; and

(B) by striking subclauses (V) and (VI)  
and inserting the following new subclause:

1 “(V) on or after October 1, 2000, ‘c’  
2 is equal to 1.6.”.

3 (2) TECHNICAL AMENDMENTS.—Section  
4 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as  
5 amended by paragraph (1), is amended—

6 (A) by realigning the left margins of  
7 clauses (ii) and (v) so as to align with the left  
8 margin of clause (i); and

9 (B) by realigning the left margins of sub-  
10 clauses (I) through (V) of clause (ii) appro-  
11 priately.

12 (b) SPECIAL ADJUSTMENT FOR PURPOSES OF MAIN-  
13 TAINING 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR  
14 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-  
15 tion 1886(d) of the Social Security Act (42 U.S.C.  
16 1395ww(d)(5)(B)(ii)(V)), as amended by subsection (a),  
17 for purposes of making payments for subsection (d) hos-  
18 pitals (as defined in paragraph (1)(B) of such section)  
19 with indirect costs of medical education, the indirect  
20 teaching adjustment factor referred to in paragraph  
21 (5)(B)(ii) of such section shall be determined—

22 (1) for discharges occurring on or after October  
23 1, 2000, and before April 1, 2001, pursuant to such  
24 paragraph as in effect on the day before the date of  
25 enactment of this Act; and

1           (2) for discharges occurring on or after April 1,  
 2           2001, and before October 1, 2001, by substituting  
 3           “1.66” for “1.6” in subclause (V) of such paragraph  
 4           (as so amended).

5           (c) CONFORMING AMENDMENT RELATING TO DE-  
 6           TERMINATION OF STANDARDIZED AMOUNT.—Section  
 7           1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is  
 8           amended—

9           (1) by inserting a comma after “Balanced  
 10          Budget Act of 1997”; and

11          (2) by inserting “, or any payment under such  
 12          paragraph resulting from the application of section  
 13          111(b) of the Medicare, Medicaid, and SCHIP Bal-  
 14          anced Budget Refinement Act of 2000” after “Bal-  
 15          anced Budget Refinement Act of 1999”.

16   **SEC. 112. ELIMINATING REDUCTION IN PPS HOSPITAL PAY-**  
 17                                   **MENT UPDATE.**

18          (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42  
 19          U.S.C. 1395ww(b)(3)(B)(i)) is amended—

20          (1) in subclause (XV), by adding “and” at the  
 21          end;

22          (2) by striking subclauses (XVI) and (XVII);

23          (3) by redesignating subclause (XVIII) as sub-  
 24          clause (XVI); and

1 (4) in subclause (XVI), as so redesignated, by  
 2 striking “fiscal year 2003” and inserting “fiscal year  
 3 2001”.

4 (b) SPECIAL RULE FOR PAYMENT FOR INPATIENT  
 5 HOSPITAL SERVICES FOR FISCAL YEAR 2001.—Notwith-  
 6 standing the amendments made by subsection (a), for pur-  
 7 poses of making payments for fiscal year 2001 for inpa-  
 8 tient hospital services furnished by subsection (d) hos-  
 9 pitals (as defined in section 1886(d)(1)(B) of the Social  
 10 Security Act (42 U.S.C. 1395ww(d)(1)(B))), the “applica-  
 11 ble percentage increase” referred to in section  
 12 1886(b)(3)(B)(i) of such Act (42 U.S.C.  
 13 1395ww(b)(3)(B)(i))—

14 (1) for discharges occurring on or after October  
 15 1, 2000, and before April 1, 2001, shall be deter-  
 16 mined in accordance with subclause (XVI) of such  
 17 section as in effect on the day before the date of en-  
 18 actment of this Act; and

19 (2) for discharges occurring on or after April 1,  
 20 2001, and before October 1, 2001, shall be equal  
 21 to—

22 (A) the market basket percentage increase  
 23 plus 1.1 percentage points for hospitals (other  
 24 than sole community hospitals) in all areas; and

1 (B) the market basket percentage increase  
 2 for sole community hospitals.

3 **SEC. 113. ELIMINATING REDUCTION IN DISPROPOR-**  
 4 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

5 (a) ELIMINATION OF REDUCTION.—

6 (1) IN GENERAL.—Section 1886(d)(5)(F)(ix)  
 7 (42 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

8 (A) in subclause (III), by striking “during  
 9 each of fiscal years 2000 and 2001” and insert-  
 10 ing “during fiscal year 2000”;

11 (B) by striking subclause (IV);

12 (C) by redesignating subclause (V) as sub-  
 13 clause (IV); and

14 (D) in subclause (IV), as so redesignated,  
 15 by striking “during fiscal year 2003” and in-  
 16 serting “during fiscal year 2001”.

17 (2) EFFECTIVE DATE.—The amendments made  
 18 by this subsection shall apply to discharges occur-  
 19 ring on or after October 1, 2000.

20 (b) SPECIAL RULE FOR DSH PAYMENT FOR FISCAL  
 21 YEAR 2001.—Notwithstanding the amendments made by  
 22 subsection (a)(1), for purposes of making disproportionate  
 23 share payments for subsection (d) hospitals (as defined  
 24 in section 1886(d)(1)(B) of the Social Security Act (42  
 25 U.S.C. 1395ww(d)(1)(B))) for fiscal year 2001, the addi-

1 tional payment amount otherwise determined under clause  
 2 (ii) of section 1886(d)(5)(F) of the Social Security Act  
 3 (42 U.S.C. 1395ww(d)(5)(F))—

4 (1) for discharges occurring on or after October  
 5 1, 2000, and before April 1, 2001, shall be adjusted  
 6 as provided by clause (ix)(III) of such section as in  
 7 effect on the day before the date of enactment of  
 8 this Act; and

9 (2) for discharges occurring on or after April 1,  
 10 2001, and before October 1, 2001, shall be increased  
 11 by 3 percent.

12 (c) CONFORMING AMENDMENTS RELATING TO DE-  
 13 TERMINATION OF STANDARDIZED AMOUNT.—Section  
 14 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is  
 15 amended—

16 (1) by striking “Act of 1989 or” and inserting  
 17 “Act of 1989,”; and

18 (2) by inserting “, or the enactment of section  
 19 113(b) of the Medicare, Medicaid, and SCHIP Bal-  
 20 anced Budget Refinement Act of 2000” after “Om-  
 21 nibus Budget Reconciliation Act of 1990”.



1 **SEC. 114. EQUALIZING THE THRESHOLD AND UPDATING**  
 2 **PAYMENT FORMULAS FOR DISPROPOR-**  
 3 **TIONATE SHARE HOSPITALS.**

4 (a) APPLICATION OF UNIFORM 15 PERCENT  
 5 THRESHOLD.—Section 1886(d)(5)(F)(v) (42 U.S.C.  
 6 1395ww(d)(5)(F)(v)) is amended by striking “exceeds—  
 7 ” and all that follows and inserting “exceeds 15 percent.”.

8 (b) CHANGE IN PAYMENT PERCENTAGE FOR-  
 9 MULAS.—Section 1886(d)(5)(F)(viii) (42 U.S.C.  
 10 1395ww(d)(5)(F)(viii)) is amended to read as follows:

11 “(viii) The formula used to determine the dispropor-  
 12 tionate share adjustment percentage for a cost reporting  
 13 period for a hospital described in subclause (II), (III), or  
 14 (IV) of clause (iv) is—

15 “(I) in the case of such a hospital with a dis-  
 16 proportionate patient percentage (as defined in  
 17 clause (vi)) that does not exceed 20.2,  $(P-15)(.65)$   
 18  $+ 2.5$ ;

19 “(II) in the case of such a hospital with a dis-  
 20 proportionate patient percentage (as so defined) that  
 21 exceeds 20.2 but does not exceed 25.2,  $(P-$   
 22  $20.2)(.825) + 5.88$ ;

23 “(III) except as provided in subclause (IV), in  
 24 the case of such a hospital with a disproportionate  
 25 patient percentage (as so defined) that exceeds 25.2,

1 the disproportionate share adjustment percentage =  
 2 10; and

3 “(IV) in the case of such a hospital with a dis-  
 4 proportionate patient percentage (as so defined) that  
 5 exceeds 30.0 and that is described in clause (iv)(III),  
 6  $(P-30)(.6) + 10$ ;

7 where ‘P’ is the hospital’s disproportionate patient per-  
 8 centage (as so defined).”.

9 (c) CONFORMING AMENDMENTS.—Section  
 10 1886(d)(5)(F)(iv) (42 U.S.C. 1395ww(d)(5)(F)(iv)) is  
 11 amended—

12 (1) in subclause (I), by striking “is described in  
 13 the second sentence of clause (v)” and inserting “is  
 14 located in a rural area and has 500 or more beds”;

15 (2) by amending subclause (II) to read as fol-  
 16 lows:

17 “(II) is located in an urban area and has less  
 18 than 100 beds, or is located in a rural area and has  
 19 less than 500 beds and is not described in subclause  
 20 (III) or (IV), is equal to the percent determined in  
 21 accordance with the applicable formula described in  
 22 clause (viii);”;

23 (3) by striking subclauses (III) and (IV);

24 (4) by redesignating subclauses (V) and (VI) as  
 25 subclauses (III) and (IV), respectively;

1 (5) in subclause (III) (as so redesignated), by  
 2 striking “and is not classified as a sole community  
 3 hospital under subparagraph (D),”; and

4 (6) in subclause (IV) (as so redesignated), by  
 5 striking “10 percent” and inserting “equal to the  
 6 percent determined in accordance with the applicable  
 7 formula described in clause (viii)”.

8 (d) EFFECTIVE DATE.—The amendments made by  
 9 this section shall apply to discharges occurring on or after  
 10 April 1, 2001.

11 **SEC. 115. CARE FOR LOW-INCOME PATIENTS.**

12 (a) FREEZE IN MEDICAID DSH ALLOTMENTS.—

13 (1) IN GENERAL.—Section 1923(f) (42 U.S.C.  
 14 1396r–4(f)) is amended—

15 (A) by redesignating paragraph (4) as  
 16 paragraph (5); and

17 (B) by inserting after paragraph (3), the  
 18 following new paragraph:

19 “(4) SPECIAL RULE FOR FISCAL YEARS 2001  
 20 THROUGH 2008.—With respect to each of fiscal years  
 21 2001 through 2008—

22 “(A) paragraph (2) shall be applied—

23 “(i) by substituting—

24 “(I) in the heading, ‘2001’ for  
 25 ‘2002’;

1 “(II) in the matter preceding the  
 2 table, ‘2001 (and the DSH allotment  
 3 for a State for fiscal year 2001 is the  
 4 same as the DSH allotment for the  
 5 State for fiscal year 2000, as deter-  
 6 mined under the following table)’ for  
 7 ‘2002’; and

8 “(ii) without regard to the columns in  
 9 the table relating to FY 01 and FY 02  
 10 (fiscal years 2001 and 2002); and

11 “(B) paragraph (3) shall be applied by  
 12 substituting—

13 “(i) in the heading, ‘2002’ for ‘2003’;

14 “(ii) in subparagraph (A), ‘2002’ for  
 15 ‘2003’.”.

16 (2) REPEAL; APPLICABILITY.—Effective Octo-  
 17 ber 1, 2008, the amendments made by paragraph  
 18 (1) are repealed and section 1923(f) of the Social  
 19 Security Act (42 U.S.C. 1396r–4(f)) shall be applied  
 20 and administered as if such amendments had not  
 21 been enacted.

22 (b) INCREASE IN DSH ALLOTMENTS FOR THE DIS-  
 23 TRICT OF COLUMBIA.—

24 (1) IN GENERAL.—Each of the entries in the  
 25 table in section 1923(f)(2) (42 U.S.C. 1396r–

1 4(f)(2)) relating to the District of Columbia for FY  
 2 98 (fiscal year 1998), for FY 99 (fiscal year 1999),  
 3 for FY 00 (fiscal year 2000), for FY 01 (fiscal year  
 4 2001), and for FY 02 (fiscal year 2002) are amend-  
 5 ed by striking the amount otherwise specified and  
 6 inserting “43.4”.

7 (2) EFFECTIVE DATE.—The amendments made  
 8 by paragraph (1) shall take effect as if included in  
 9 the enactment of section 4721(a) of BBA (111 Stat.  
 10 511).

11 (c) OPTIONAL ELIGIBILITY OF CERTAIN ALIEN  
 12 PREGNANT WOMEN AND CHILDREN FOR MEDICAID AND  
 13 SCHIP.—

14 (1) MEDICAID.—Section 1903(v) (42 U.S.C.  
 15 1396b(v)) is amended—

16 (A) in paragraph (1), by striking “para-  
 17 graph (2)” and inserting “paragraphs (2) and  
 18 (4)”; and

19 (B) by adding at the end the following new  
 20 paragraph:

21 “(4)(A) A State may elect (in a plan amendment  
 22 under this title) to provide medical assistance under this  
 23 title, notwithstanding sections 401(a), 402(b), 403, and  
 24 421 of the Personal Responsibility and Work Opportunity  
 25 Reconciliation Act of 1996, for aliens who are lawfully re-

1 siding in the United States (including battered aliens de-  
 2 scribed in section 431(c) of such Act) and who are other-  
 3 wise eligible for such assistance, within any of the fol-  
 4 lowing eligibility categories:

5 “(i) PREGNANT WOMEN.—Women during preg-  
 6 nancy (and during the 60-day period beginning on  
 7 the last day of the pregnancy).

8 “(ii) CHILDREN.—Children (as defined under  
 9 such plan), including optional targeted low-income  
 10 children described in section 1905(u)(2)(B).

11 “(B) In the case of a State that has elected to provide  
 12 medical assistance to a category of aliens under subpara-  
 13 graph (A), no action may be brought under an affidavit  
 14 of support against any sponsor of such an alien on the  
 15 basis of provision of assistance to such category.”.

16 (2) SCHIP.—Section 2107(e)(1) (42 U.S.C.  
 17 1397gg(e)(1)) is amended by adding at the end the  
 18 following new subparagraph:

19 “(D) Section 1903(v)(4)(A)(ii) (relating to  
 20 optional coverage of permanent resident alien  
 21 children), but only if the State has in effect an  
 22 election under that same eligibility category for  
 23 purposes of title XIX.”.

24 (3) EFFECTIVE DATE.—The amendments made  
 25 by this section take effect on October 1, 2000, and

1        apply to medical assistance and child health assist-  
 2        ance furnished on or after such date.

3    **SEC. 116. MODIFICATION OF PAYMENT RATE FOR PUERTO**  
 4        **RICO HOSPITALS.**

5        (a) MODIFICATION OF PAYMENT RATE.—Section  
 6    1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is  
 7    amended—

8            (1) in clause (i), by striking “October 1, 1997,  
 9        50 percent (” and inserting “October 1, 2000, 25  
 10       percent (for discharges between October 1, 1997,  
 11       and September 30, 2000, 50 percent,”; and

12            (2) in clause (ii), in the matter preceding sub-  
 13       clause (I), by striking “after October 1, 1997, 50  
 14       percent (” and inserting “after October 1, 2000, 75  
 15       percent (for discharges between October 1, 1997,  
 16       and September 30, 2000, 50 percent,”.

17        (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 18    2001.—

19            (1) IN GENERAL.—Notwithstanding the amend-  
 20       ment made by subsection (a), for purposes of mak-  
 21       ing payments for the operating costs of inpatient  
 22       hospital services of a section 1886(d) Puerto Rico  
 23       hospital for fiscal year 2001, the amount referred to  
 24       in the matter preceding clause (i) of section

1 1886(d)(9)(A) of the Social Security Act (42 U.S.C.  
2 1395ww(d)(9)(A))—

3 (A) for discharges occurring on or after  
4 October 1, 2000, and before April 1, 2001,  
5 shall be determined in accordance with such  
6 section as in effect on the day before the date  
7 of enactment of this Act; and

8 (B) for discharges occurring on or after  
9 April 1, 2001, and before October 1, 2001,  
10 shall be determined—

11 (i) using 0 percent of the Puerto Rico  
12 adjusted DRG prospective payment rate  
13 referred to in clause (i) of such section;  
14 and

15 (ii) using 100 percent of the dis-  
16 charge-weighted average referred to in  
17 clause (ii) of such section.

18 (2) SECTION 1886(d) PUERTO RICO HOSPITAL.—  
19 For purposes of this subsection, the term “section  
20 1886(d) Puerto Rico hospital” has the meaning  
21 given the term “subsection (d) Puerto Rico hospital”  
22 in the last sentence of section 1886(d)(9)(A) of the  
23 Social Security Act (42 U.S.C. 1395ww(d)(9)(A)).



1 **SEC. 117. MEDPAC STUDY ON HOSPITAL AREA WAGE IN-**  
2 **DEXES.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Medicare Payment Ad-  
5 visory Commission established under section 1805 of  
6 the Social Security Act (42 U.S.C. 1395b–6) (in this  
7 section referred to as “MedPAC”) shall conduct a  
8 study on the hospital area wage indexes used in  
9 making payments to hospitals under section 1886(d)  
10 of the Social Security Act (42 U.S.C. 1395ww(d)),  
11 including an assessment of the accuracy of those in-  
12 dexes in reflecting geographic differences in wage  
13 and wage-related costs of hospitals.

14 (2) CONSIDERATIONS.—In conducting the study  
15 under paragraph (1), MedPAC shall consider—

16 (A) the appropriate method for deter-  
17 mining hospital area wage indexes;

18 (B) the appropriate portion of hospital  
19 payments that should be adjusted by the appli-  
20 cable area wage index;

21 (C) the appropriate method for adjusting  
22 the wage index by occupational mix; and

23 (D) the feasibility and impact of making  
24 changes (as determined appropriate by  
25 MedPAC) to the methods used to determine

1           such indexes, including the need for a data sys-  
2           tem required to implement such changes.

3           (b) REPORT.—Not later than 18 months after the  
4   date of enactment of this Act, MedPAC shall submit a  
5   report to the Secretary of Health and Human Services and  
6   Congress on the study conducted under subsection (a) to-  
7   gether with such recommendations for legislation and ad-  
8   ministrative action as MedPAC determines appropriate.

## 9   **Subtitle C—PPS Exempt Hospitals**

### 10 **SEC. 121. TREATMENT OF CERTAIN CANCER HOSPITALS.**

11           (a) IN GENERAL.—Section 1886(d)(1)(B)(v) of the  
12   Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)) is  
13   amended—

14           (1) in subclause (I), by striking “or” at the  
15   end;

16           (2) in subclause (II), by striking the semicolon  
17   at the end and inserting “, or”; and

18           (3) by adding at the end the following:

19           “(III) a hospital that was recognized as a clin-  
20   ical cancer research center by the National Cancer  
21   Institute of the National Institutes of Health as of  
22   February 18, 1998, that has never been reimbursed  
23   for inpatient hospital services pursuant to a reim-  
24   bursement system under a demonstration project  
25   under section 1814(b), that is a freestanding facility

1 organized primarily for treatment of and research on  
 2 cancer and is not a unit of another hospital, that as  
 3 of the date of enactment of this subclause, is li-  
 4 censed for 162 acute care beds, and that dem-  
 5 onstrates for the 4-year period ending on June 30,  
 6 1999, that at least 50 percent of its total discharges  
 7 have a principal finding of neoplastic disease, as de-  
 8 fined in subparagraph (E);”.

9 (b) CONFORMING AMENDMENT.—Section  
 10 1886(d)(1)(E) of the Social Security Act (42 U.S.C.  
 11 1395ww(d)(1)(E)) is amended by striking “For purposes  
 12 of subparagraph (B)(v)(II)” and inserting “For purposes  
 13 of subclauses (II) and (III) of subparagraph (B)(v)”.

14 (c) PAYMENT.—

15 (1) APPLICATION TO COST REPORTING PERI-  
 16 ODS.—Any classification by reason of section  
 17 1886(d)(1)(B)(v)(III) of the Social Security Act (as  
 18 added by subsection (a)) shall apply to 12-month  
 19 cost reporting periods beginning on or after July 1,  
 20 1999.

21 (2) BASE YEAR.—Notwithstanding the provi-  
 22 sions of section 1886(b)(3)(E) of such Act (42  
 23 U.S.C. 1395ww(b)(3)(E)) or other provisions to the  
 24 contrary, the base cost reporting period for purposes  
 25 of determining the target amount for any hospital

1       classified by reason of section 1886(d)(1)(B)(v)(III)  
 2       of such Act (as added by subsection (a)) shall be the  
 3       12-month cost reporting period beginning on July 1,  
 4       1995.

5           (3) DEADLINE FOR PAYMENTS.—Any payments  
 6       owed to a hospital by reason of this subsection shall  
 7       be made expeditiously, but in no event later than 1  
 8       year after the date of enactment of this Act.

9   **SEC. 122. PAYMENT ADJUSTMENT FOR INPATIENT SERV-**  
 10       **ICES IN REHABILITATION HOSPITALS.**

11       (a) OPTION TO APPLY PROSPECTIVE PAYMENT SYS-  
 12       TEM DURING TRANSITION PERIOD.—Section  
 13       1886(j)(1)(A) (42 U.S.C. 1395ww(j)(1)(A)) is amended in  
 14       the matter preceding subclause (i) by inserting “the great-  
 15       er of the prospective payment rate determined in para-  
 16       graph (3)(A) or” after “is equal to”.

17       (b) INCREASE IN PROSPECTIVE PAYMENT PERCENT-  
 18       AGE DURING TRANSITION PERIOD.—Section  
 19       1886(j)(1)(A)(ii)(I) (42 U.S.C. 1395ww(j)(1)(A)(ii)(I)) is  
 20       amended by inserting “102 percent of” before “the per  
 21       unit”.

22       (c) EFFECTIVE DATE.—The amendments made by  
 23       this section shall take effect as if included in the enact-  
 24       ment of section 4421 of BBA (111 Stat. 410).

## 1                   **Subtitle D—Hospice Care**

### 2   **SEC. 131. REVISION IN PAYMENTS FOR HOSPICE CARE.**

3           (a) INCREASE.—Section 1814(i)(1)(C) of the Social  
4 Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

5               (1) in clause (i), by adding at the end the fol-  
6           lowing new sentence: “With respect to routine home  
7           care and other services included in hospice care fur-  
8           nished during fiscal year 2001, the payment rates  
9           for such care and services for such fiscal year shall  
10          be 110 percent of such rates as would otherwise be  
11          in effect for such fiscal year (taking into account the  
12          increase under clause (ii) but not taking into ac-  
13          count the increase under section 131 of the Medi-  
14          care, Medicaid, and SCHIP Balanced Budget Re-  
15          finement Act of 1999), and such payment rates shall  
16          be used in determining payments for such care and  
17          services furnished in a subsequent fiscal year under  
18          clause (ii).”; and

19              (2) in clause (ii), by striking “during a subse-  
20          quent fiscal year” and inserting “during a fiscal  
21          year beginning after September 30, 1990”.

22          (b) ELIMINATING REDUCTION IN UPDATE.—Section  
23 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.  
24 1395f(i)(1)(C)(ii)) is amended—

1 (1) in subclause (VI), by striking “through  
2 2002” and inserting “through 2000”; and

3 (2) in subclause (VII), by striking “for a subse-  
4 quent fiscal year” and inserting “for fiscal year  
5 2001 and each subsequent fiscal year”.

6 (c) SPECIAL RULE FOR PAYMENT FOR HOSPICE  
7 CARE FOR FISCAL YEAR 2001.—Notwithstanding the  
8 amendments made by subsections (a) and (b), for pur-  
9 poses of making payments under section 1814(i)(1)(C) of  
10 the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for  
11 routine home care and other services included in hospice  
12 care furnished during fiscal year 2001, such payment  
13 rates shall be determined—

14 (1) for the period beginning on October 1,  
15 2000, and ending on March 31, 2001, in accordance  
16 with such section as in effect on the day before the  
17 date of enactment of this Act; and

18 (2) for the period beginning on April 1, 2001,  
19 and ending on September 30, 2001—

20 (A) by substituting “120 percent” for  
21 “110 percent” in the second sentence of clause  
22 (i) of such section (as added by subsection  
23 (a)(1)); and

24 (B) as if the increase under subclause  
25 (ii)(VII) (as amended by subsection (b)) for fis-

1 cal year 2001 was equal to the market basket  
 2 increase for the fiscal year plus 1.0 percentage  
 3 point.

## 4 **Subtitle E—Other Provisions**

### 5 **SEC. 141. HOSPITALS REQUIRED TO COMPLY WITH** 6 **BLOODBORNE PATHOGENS STANDARD.**

7 (a) AGREEMENTS WITH HOSPITALS.—Section  
 8 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

9 (1) in subparagraph (R), by striking “and” at  
 10 the end;

11 (2) in subparagraph (S), by striking the period  
 12 at the end and inserting “, and”; and

13 (3) by inserting after subparagraph (S) the fol-  
 14 lowing new subparagraph:

15 “(T) in the case of hospitals that are not other-  
 16 wise subject to regulation by the Occupational Safe-  
 17 ty and Health Administration, to comply with the  
 18 Bloodborne Pathogens standard under section  
 19 1910.1030 of title 29 of the Code of Federal Regula-  
 20 tions.”.

21 (b) EFFECTIVE DATE.—The amendments made by  
 22 this section shall apply to agreements in effect on or after  
 23 the date that is 1 year after the date of enactment of this  
 24 Act.

1 **SEC. 142. INFORMATICS AND DATA SYSTEMS GRANT PRO-**  
2 **GRAM.**

3 (a) GRANTS TO HOSPITALS.—

4 (1) IN GENERAL.—The Secretary of Health and  
5 Human Services (in this section referred to as the  
6 “Secretary”) shall establish a program to make  
7 grants to hospitals that have submitted applications  
8 in accordance with subsection (c) to assist such hos-  
9 pitals in offsetting the costs related to—

10 (A) developing and implementing standard-  
11 ized clinical health care informatics systems de-  
12 signed to improve medical care and reduce ad-  
13 verse events and health care complications re-  
14 sulting from medication errors; and

15 (B) establishing data systems to comply  
16 with the administrative simplification require-  
17 ments under part C of title XI of the Social Se-  
18 curity Act (42 U.S.C. 1320d et seq.).

19 (2) COSTS.—For purposes of paragraph (1),  
20 the term “costs” shall include costs associated  
21 with—

22 (A) purchasing computer software and  
23 hardware; and

24 (B) providing education and training to  
25 hospital staff on computer information systems.



1           (3) DURATION.—The authority of the Secretary  
2           to make grants under this section shall terminate on  
3           September 30, 2011.

4           (4) LIMITATION.—A hospital that has received  
5           a grant under section 1611 of the Public Health  
6           Service Act (as added by section 447 of this Act) is  
7           not eligible to receive a grant under this section.

8           (b) SPECIAL CONSIDERATION FOR LARGE URBAN  
9           HOSPITALS.—In awarding grants under this section, the  
10          Secretary shall give special consideration to hospitals lo-  
11          cated in large urban areas (as defined for purposes of sec-  
12          tion 1886(d) of the Social Security Act (42 U.S.C.  
13          1395ww(d)).

14          (c) APPLICATION.—A hospital seeking a grant under  
15          this section shall submit an application to the Secretary  
16          at such time and in such form and manner as the Sec-  
17          retary specifies.

18          (d) REPORTS.—

19                (1) INFORMATION.—A hospital receiving a  
20                grant under this section shall furnish the Secretary  
21                with such information as the Secretary may require  
22                to—

23                        (A) evaluate the project for which the  
24                        grant is made; and

1 (B) ensure that the grant is expended for  
2 the purposes for which it is made.

3 (2) TIMING OF SUBMISSION.—

4 (A) INTERIM REPORTS.—The Secretary  
5 shall report to the Committee on Ways and  
6 Means of the House of Representatives and the  
7 Committee on Finance of the Senate at least  
8 annually on the grant program established  
9 under this section, including in such report in-  
10 formation on the number of grants made, the  
11 nature of the projects involved, the geographic  
12 distribution of grant recipients, and such other  
13 matters as the Secretary deems appropriate.

14 (B) FINAL REPORT.—The Secretary shall  
15 submit a final report to such committees not  
16 later than 180 days after the completion of all  
17 of the projects for which a grant is made under  
18 this section.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
20 are authorized to be appropriated from the Federal Hos-  
21 pital Insurance Trust Fund under section 1817 of the So-  
22 cial Security Act (42 U.S.C. 1395i) \$25,000,000 for each  
23 of the fiscal years 2001 through 2011 for the purposes  
24 of making grants under this section.

1 **SEC. 143. RELIEF FROM MEDICARE PART A LATE ENROLL-**  
 2 **MENT PENALTY FOR GROUP BUY-IN FOR**  
 3 **STATE AND LOCAL RETIREES.**

4 Section 1818(d) (42 U.S.C. 1395i-2(d)) is amended  
 5 by adding at the end the following new paragraph:

6 “(6)(A) In the case where a State, a political  
 7 subdivision of a State, or an agency or instrumen-  
 8 tality of a State or political subdivision thereof de-  
 9 termines to pay, for the life of each individual, the  
 10 monthly premiums due under paragraph (1) on be-  
 11 half of each of the individuals in a qualified State  
 12 or local government retiree group who meets the  
 13 conditions of subsection (a), the amount of any in-  
 14 crease otherwise applicable under section 1839(b)  
 15 (as modified by subsection (c)(6) of this section)  
 16 with respect to the monthly premium for benefits  
 17 under this part for an individual who is a member  
 18 of such group shall be reduced by the total amount  
 19 of taxes paid under section 3101(b) of the Internal  
 20 Revenue Code of 1986 by such individual and under  
 21 section 3111(b) by the employers of such individual  
 22 on behalf of such individual with respect to employ-  
 23 ment (as defined in section 3121(b) of such Code).

24 “(B) For purposes of this paragraph, the term  
 25 ‘qualified State or local government retiree group’  
 26 means all of the individuals who retire prior to a

1 specified date that is before January 1, 2002, from  
 2 employment in 1 or more occupations or other broad  
 3 classes of employees of—

4 “(i) the State;

5 “(ii) a political subdivision of the State; or

6 “(iii) an agency or instrumentality of the  
 7 State or political subdivision of the State.”.

## 8 **Subtitle F—Transitional Provisions**

### 9 **SEC. 151. RECLASSIFICATION OF CERTAIN COUNTIES AND** 10 **AREAS FOR PURPOSES OF REIMBURSEMENT** 11 **UNDER THE MEDICARE PROGRAM.**

12 (a) FISCAL YEARS 2002 THROUGH 2004.—Notwith-  
 13 standing any other provision of law, effective for dis-  
 14 charges occurring during fiscal years 2002, 2003, and  
 15 2004, for purposes of making payments under section  
 16 1886(d) of the Social Security Act (42 U.S.C.  
 17 1395ww(d))—

18 (1) Iredell County, North Carolina is deemed to  
 19 be located in the Charlotte-Gastonia-Rock Hill,  
 20 North Carolina-South Carolina Metropolitan Statis-  
 21 tical Area; and

22 (2) the large urban area of New York, New  
 23 York is deemed to include Orange County, New  
 24 York (including hospitals that have been reclassified  
 25 into such county).

1 For purposes of that section, any reclassification under  
 2 this subsection shall be treated as a decision of the Medi-  
 3 care Geographic Classification Review Board under para-  
 4 graph (10) of that section.

5 (b) FISCAL YEARS 2001 THROUGH 2003.—Notwith-  
 6 standing any other provision of law, effective for dis-  
 7 charges occurring during fiscal years 2001, 2002, and  
 8 2003, for purposes of making payments under section  
 9 1886(d) of the Social Security Act (42 U.S.C.  
 10 1395ww(d))—

11 (1) the Jackson, Michigan Metropolitan Statis-  
 12 tical Area is deemed to be located in the Ann Arbor,  
 13 Michigan Metropolitan Statistical Area;

14 (2) Tangipahoa Parish, Louisiana is deemed to  
 15 be located in the New Orleans, Louisiana Metropoli-  
 16 tan Statistical Area; and

17 (3) the large urban area of New York, New  
 18 York is deemed to include Dutchess County, New  
 19 York.

20 For purposes of that section, any reclassification under  
 21 this subsection shall be treated as a decision of the Medi-  
 22 care Geographic Classification Review Board under para-  
 23 graph (10) of that section.

24 (c) TECHNICAL CORRECTION TO BBRA.—

1 (1) IN GENERAL.—Section 152 of BBRA (113  
2 Stat. 1501A–334) is amended—

3 (A) in subsection (a)(2), by inserting “(in-  
4 cluding hospitals that have been reclassified  
5 into such county)” after “such county”; and

6 (B) in subsection (b)(2), by inserting “(in-  
7 cluding hospitals that have been reclassified  
8 into such county)” after “Orange County, New  
9 York”.

10 (2) EFFECTIVE DATE.—The amendments made  
11 by paragraph (1) shall take effect as if included in  
12 the enactment of section 152 of BBRA (113 Stat.  
13 1501A–334).

14 **SEC. 152. CALCULATION AND APPLICATION OF WAGE**  
15 **INDEX FLOOR FOR A CERTAIN AREA.**

16 Notwithstanding any other provision of section  
17 1886(d) of the Social Security Act (42 U.S.C.  
18 1395ww(d)), for discharges occurring during fiscal year  
19 2000, the Secretary of Health and Human Services shall  
20 calculate and apply the wage index for the Barnstable-  
21 Yarmouth Metropolitan Statistical Area under that sec-  
22 tion as if the Jordan Hospital were classified in such area  
23 for purposes of payment under that section for such fiscal  
24 year. Such recalculation shall not affect the wage index  
25 for any other area.

**TITLE II—PROVISIONS**  
**RELATING TO PART B**  
**Subtitle A—Hospital Outpatient**  
**Services**

**SEC. 201. REDUCTION OF EFFECTIVE HOPD COINSURANCE**

**RATE TO 20 PERCENT BY 2019.**

Section 1833(t)(3)(B)(ii) (42 U.S.C.

1395l(t)(3)(B)(ii)) is amended—

(1) by striking “If the” and inserting:

“(I) IN GENERAL.—If the”; and

(2) by adding at the end the following new sub-  
 clause:

“(II) ACCELERATED PHASE-IN.—

The Secretary shall estimate, prior to  
 January 1, 2002, the unadjusted co-  
 payment amount for each such service  
 (or groups of such services). If the  
 Secretary estimates such unadjusted  
 copayment amount to be greater than  
 20 percent for any such service (or  
 group of such services) on or after  
 January 1, 2019, the Secretary shall,  
 for services furnished beginning on or  
 after January 1, 2002, reduce the  
 unadjusted copayment amount for

1           such service (or group of such serv-  
 2           ices) in equal increments each year,  
 3           from the amount applicable in 2001,  
 4           by an amount estimated by the Sec-  
 5           retary such that the unadjusted co-  
 6           payment amount shall equal 20 per-  
 7           cent beginning on or after January 1,  
 8           2019.”.

9   **SEC. 202. APPLICATION OF TRANSITIONAL CORRIDOR TO**  
 10                   **CERTAIN HOSPITALS THAT DID NOT SUBMIT**  
 11                   **A 1996 COST REPORT.**

12       (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42  
 13 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or,  
 14 in the case of a hospital that did not submit a cost report  
 15 for such period, during the first cost reporting period end-  
 16 ing in a year after 1996 and before 2001 for which the  
 17 hospital submitted a cost report)” after “1996”.

18       (b) EFFECTIVE DATE.—The amendment made by  
 19 subsection (a) shall take effect as if included in the enact-  
 20 ment of section 202 of BBRA.



1 **SEC. 203. PERMANENT GUARANTEE OF PRE-BBA PAYMENT**  
 2 **LEVELS FOR OUTPATIENT SERVICES FUR-**  
 3 **NISHED BY CHILDREN'S HOSPITALS.**

4 (a) IN GENERAL.—Section 1833(t)(7)(D) (42 U.S.C.  
 5 1395l(t)(7)(D)), as amended by section 432, is  
 6 amended—

7 (1) in the heading, by inserting “, CHIL-  
 8 DREN’S,” after “SMALL RURAL”; and

9 (2) by striking “section 1886(d)(1)(B)(v)” and  
 10 inserting “clause (iii) or (v) of section  
 11 1886(d)(1)(B)”.

12 (b) EFFECTIVE DATE.—The amendments made by  
 13 subsection (a) shall apply to services provided on or after  
 14 the date that is 1 year after the date of enactment of this  
 15 Act.

16 **Subtitle B—Provisions Relating to**  
 17 **Physicians**

18 **SEC. 211. LOAN DEFERMENT FOR RESIDENTS.**

19 (a) FAIRNESS IN MEDICAL STUDENT LOAN FINANC-  
 20 ING.—

21 (1) ELIGIBILITY REQUIREMENTS.—Section  
 22 427(a)(2)(C)(iii) of the Higher Education Act of  
 23 1965 (20 U.S.C. 1077(a)(2)(C)(iii)) is amended by  
 24 inserting before the semicolon the following: “, ex-  
 25 cept that for a medical student such period shall not  
 26 exceed the full initial residency period”.

1           (2) INSURANCE PROGRAM AGREEMENTS.—Sec-  
 2           tion 428(b)(1)(M)(iii) of the Higher Education Act  
 3           of 1965 (20 U.S.C. 1078(b)(1)(M)(iii)) is amended  
 4           by inserting before the semicolon the following: “,  
 5           except that for a medical student such period shall  
 6           not exceed the full initial residency period”.

7           (3) DEFERMENT ELIGIBILITY.—Section  
 8           455(f)(2)(C) of the Higher Education Act of 1965  
 9           (20 U.S.C. 1087e(f)(2)(C)) is amended by inserting  
 10          before the period the following: “, except that for a  
 11          medical student such period shall not exceed the full  
 12          initial residency period”.

13          (4) CONTENTS OF LOAN AGREEMENT.—Section  
 14          464(c)(2)(A)(iii) of the Higher Education Act of  
 15          1965 (20 U.S.C. 1087dd(c)(2)(A)(iii)) is amended  
 16          by inserting before the semicolon the following: “,  
 17          except that for a medical student such period shall  
 18          not exceed the full initial residency period”.

19          (b) FAIRNESS IN ECONOMIC HARDSHIP DETERMINA-  
 20          TION.—Section 435(o)(1)(B) of the Higher Education Act  
 21          of 1965 (20 U.S.C. 1085(o)(1)(B)) is amended to read  
 22          as follows:

23                       “(B) such borrower is working full time  
 24                       and has a Federal educational debt burden that  
 25                       equals or exceeds 20 percent of such borrower’s

adjusted gross income, and the difference between such borrower's adjusted gross income minus such burden is less than 250 percent of the greater of—

“(i) the annual earnings of an individual earning the minimum wage under section 6 of the Fair Labor Standards Act of 1938; or

“(ii) the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Service Block Grant Act) applicable to a family of 2; or”.

**SEC. 212. GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS.**

(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the post-payment audit process under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the “medicare program”) as such process applies to physicians, including the proper level of resources

1       that the Health Care Financing Administration  
2       should devote to educating physicians regarding—

3               (A) coding and billing;

4               (B) documentation requirements; and

5               (C) the calculation of overpayments.

6           (2) REPORT.—Not later than 18 months after  
7       the date of enactment of this Act, the Comptroller  
8       General shall submit a report to the Secretary of  
9       Health and Human Services and Congress on the  
10      study conducted under paragraph (1) together with  
11      specific recommendations for changes or improve-  
12      ments in the post-payment audit process described  
13      in such paragraph.

14      (b) GAO STUDY ON ADMINISTRATION AND OVER-  
15      SIGHT.—

16           (1) STUDY.—The Comptroller General of the  
17      United States shall conduct a study on the aggre-  
18      gate effects of regulatory, audit, oversight, and pa-  
19      perwork burdens on physicians and other health care  
20      providers participating in the medicare program.

21           (2) REPORT.—Not later than 18 months after  
22      the date of enactment of this Act, the Comptroller  
23      General shall submit a report to the Secretary of  
24      Health and Human Services and Congress on the

1 study conducted under paragraph (1) together with  
 2 recommendations regarding any area in which—

3 (A) a reduction in paperwork, an ease of  
 4 administration, or an appropriate change in  
 5 oversight and review may be accomplished; or

6 (B) additional payments or education are  
 7 needed to assist physicians and other health  
 8 care providers in understanding and complying  
 9 with any legal or regulatory requirements.

10 **SEC. 213. MEDPAC STUDY ON THE RESOURCE-BASED PRACTICE**  
 11 **EXPENSE SYSTEM.**

12 (a) STUDY.—The Medicare Payment Advisory Com-  
 13 mission established under section 1805 of the Social Secu-  
 14 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
 15 as “MedPAC”) shall conduct a study of the refinements  
 16 to the practice expense relative value units during the  
 17 transition to a resource-based practice expense system for  
 18 physician payments under the medicare program under  
 19 title XVIII of the Social Security Act (42 U.S.C. 1395  
 20 et seq.) (in this section referred to as the “medicare pro-  
 21 gram”).

22 (b) REPORT.—Not later than July 1, 2001, MedPAC  
 23 shall submit a report to the Secretary of Health and  
 24 Human Services and Congress on the study conducted

1 under subsection (a) together with recommendations  
2 regarding—

3 (1) any change or adjustment that is appro-  
4 priate to ensure full access to a spectrum of care for  
5 beneficiaries under the medicare program; and

6 (2) the appropriateness of payments to physi-  
7 cians.

## 8 **Subtitle C—Ambulance Services**

### 9 **SEC. 221. ELECTION TO FOREGO PHASE-IN OF FEE SCHED-** 10 **ULE FOR AMBULANCE SERVICES.**

11 Section 1834(l) (42 U.S.C. 1395m(l)) is amended by  
12 adding at the end the following new paragraph:

13 “(8) ELECTION TO FOREGO PHASE-IN OF FEE  
14 SCHEDULE.—

15 “(A) IN GENERAL.—If the Secretary pro-  
16 vides for a phase-in of the fee schedule estab-  
17 lished under this subsection, a supplier of am-  
18 bulance services may make an election to re-  
19 ceive payments based only on such fee schedule  
20 at any time during such phase-in, and the Sec-  
21 retary shall begin to make payments to the sup-  
22 plier based only on such fee schedule not later  
23 than the date that is 60 days after the date on  
24 which the supplier notifies the Secretary of such  
25 election.

1 “(B) WAIVER OF BUDGET NEUTRALITY.—

2 The Secretary shall apply paragraph (3)(A) as

3 if this paragraph had not been enacted.”.

4 **SEC. 222. PRUDENT LAYPERSON STANDARD FOR EMER-**  
 5 **GENCY AMBULANCE SERVICES.**

6 (a) IN GENERAL.—Section 1861(s)(7) (42 U.S.C.  
 7 1395x(s)(7)) is amended by inserting before the semicolon  
 8 at the end the following: “, except that such regulations  
 9 shall not fail to treat ambulance services as medical and  
 10 other health services solely because the ultimate diagnosis  
 11 of the individual receiving the ambulance services results  
 12 in a conclusion that ambulance services were not nec-  
 13 essary, as long as the request for ambulance services is  
 14 made after the sudden onset of a medical condition that  
 15 would be classified as an emergency medical condition (as  
 16 defined in section 1852(d)(3)(B)).”.

17 (b) EFFECTIVE DATE.—The amendment made by  
 18 this section shall apply with respect to ambulance services  
 19 provided on or after October 1, 2000.

20 **SEC. 223. ELIMINATION OF REDUCTION IN INFLATION AD-**  
 21 **JUSTMENTS FOR AMBULANCE SERVICES.**

22 Subparagraphs (A) and (B) of section 1834(l)(3) (42  
 23 U.S.C. 1395m(l)(3)(A)) are each amended by striking “re-  
 24 duced in the case of 2001 and 2002 by 1.0 percentage

1 points” and inserting “increased in the case of 2001 by  
2 1.0 percentage point”.

3 **SEC. 224. STUDY AND REPORT ON THE COSTS OF RURAL**  
4 **AMBULANCE SERVICES.**

5 (a) STUDY.—The Secretary of Health and Human  
6 Services (in this section referred to as the “Secretary”),  
7 in consultation with the Office of Rural Health Policy,  
8 shall conduct a study of the means by which rural areas  
9 with low population densities can be identified for the pur-  
10 pose of designating areas in which the cost of providing  
11 ambulance services would be expected to be higher than  
12 similar services provided in more heavily populated areas  
13 because of low usage. Such study shall also include an  
14 analysis of the additional costs of providing ambulance  
15 services in areas designated under the previous sentence.

16 (b) REPORT.—Not later than June 30, 2001, the  
17 Secretary shall submit a report to Congress on the study  
18 conducted under subsection (a), together with a regulation  
19 based on that study which adjusts the fee schedule pay-  
20 ment rates for ambulance services provided in low density  
21 rural areas based on the increased cost of providing such  
22 services in such areas.



1 **SEC. 225. INTERIM PAYMENTS FOR RURAL GROUND AMBU-**  
 2 **LANCE SERVICES UNTIL REGULATION IMPLE-**  
 3 **MENTED.**

4 (a) INTERIM PAYMENTS.—Section 1834(l) (42  
 5 U.S.C. 1395m(l)), as amended by section 221, is amended  
 6 by adding at the end the following new paragraph:

7 “(9) INTERIM PAYMENTS FOR RURAL GROUND  
 8 AMBULANCE SERVICES.—Until such time as the fee  
 9 schedule established under this subsection is modi-  
 10 fied by the regulation described in section 224(b) of  
 11 the Medicare, Medicaid, and SCHIP Balanced  
 12 Budget Refinement Act of 2000, the amount of pay-  
 13 ment under this subsection for ground ambulance  
 14 services provided in a rural area (as defined in sec-  
 15 tion 1886(d)(2)(D)) shall be the greater of—

16 “(A) the amount determined under the fee  
 17 schedule established under this subsection  
 18 (without regard to any phase-in established pur-  
 19 suant to paragraph (2)(E)); or

20 “(B) the amount that would have been  
 21 paid for such services if the amendments made  
 22 by section 4531(b) of the Balanced Budget Act  
 23 of 1997 had not been enacted;

24 as adjusted for inflation in the manner described in  
 25 paragraph (3)(B). For purposes of this paragraph,  
 26 an ambulance trip shall be considered to have been

1 provided in a rural area only if the transportation of  
 2 the patient originated in a rural area.”.

3 (b) CONFORMING AMENDMENTS.—Section  
 4 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

5 (1) in subparagraph (R)—

6 (A) by inserting “except as provided in  
 7 subparagraph (T),” before “with respect”; and

8 (B) by striking “and” at the end; and

9 (2) in subparagraph (S), by striking the semi-  
 10 colon at the end and inserting “, and (T) with re-  
 11 spect to ambulance services described in section  
 12 1834(l)(9), the amount paid shall be 80 percent of  
 13 the lesser of the actual charge for the services or the  
 14 amount determined under such section;”.

15 (c) EFFECTIVE DATE.—The amendments made by  
 16 this section shall apply with respect to services provided  
 17 on and after January 1, 2001.

18 **SEC. 226. GAO STUDY AND REPORT ON THE COSTS OF**  
 19 **EMERGENCY AND MEDICAL TRANSPOR-**  
 20 **TATION SERVICES.**

21 (a) STUDY.—The Comptroller General of the United  
 22 States shall conduct a study of the costs of providing  
 23 emergency and medical transportation services across the  
 24 range of acuity levels of conditions for which such trans-  
 25 portation services are provided.

1 (b) REPORT.—Not later than 18 months after the  
 2 date of enactment of this Act, the Comptroller General  
 3 shall submit a report to the Secretary of Health and  
 4 Human Services and Congress on the study conducted  
 5 under subsection (a), together with recommendations for  
 6 any changes in methodology or payment level necessary  
 7 to fairly compensate suppliers of emergency and medical  
 8 transportation services and to ensure the access of bene-  
 9 ficiaries under the medicare program under title XVIII of  
 10 the Social Security Act (42 U.S.C. 1395 et seq.) to such  
 11 services.

## 12 **Subtitle D—Preventive Services**

### 13 **SEC. 231. ELIMINATION OF DEDUCTIBLES AND COINSUR-** 14 **ANCE FOR PREVENTIVE BENEFITS.**

15 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)  
 16 is amended by inserting after subsection (o) the following  
 17 new subsection:

18 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR  
 19 PREVENTIVE BENEFITS.—The Secretary may not require  
 20 the payment of any deductible or coinsurance under sub-  
 21 section (a) or (b) of any individual enrolled for coverage  
 22 under this part for any of the following preventive health  
 23 care items and services:

1           “(1) Blood-testing strips, lancets, and blood  
2           glucose monitors for individuals with diabetes de-  
3           scribed in section 1861(n).

4           “(2) Diabetes outpatient self-management  
5           training services (as defined in section 1861(qq)(1)).

6           “(3) Pneumococcal, influenza, and hepatitis B  
7           vaccines and administration described in section  
8           1861(s)(10).

9           “(4) Screening mammography (as defined in  
10          section 1861(jj)).

11          “(5) Screening pap smear and screening pelvic  
12          exam (as defined in paragraphs (1) and (2) of sec-  
13          tion 1861(nn), respectively).

14          “(6) Bone mass measurement (as defined in  
15          section 1861(rr)(1)).

16          “(7) Prostate cancer screening test (as defined  
17          in section 1861(oo)(1)).

18          “(8) Colorectal cancer screening test (as de-  
19          fined in section 1861(pp)(1)).”.

20          (b)       WAIVER       OF       COINSURANCE.—Section  
21   1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended to  
22   read as follows: “(B) with respect to preventive health care  
23   items and services described in subsection (p), the  
24   amounts paid shall be 100 percent of the fee schedule or  
25   other basis of payment under this title,”.

1 (c) WAIVER OF DEDUCTIBLE.—Section 1833(b)(1)  
 2 (42 U.S.C. 1395l(b)(1)) is amended to read as follows:  
 3 “(1) such deductible shall not apply with respect to pre-  
 4 ventive health care items and services described in sub-  
 5 section (p),”.

6 (d) ADDING “LANCET” TO DEFINITION OF DME.—  
 7 Section 1861(n) (42 U.S.C. 1395x(n)) is amended by  
 8 striking “blood-testing strips and blood glucose monitors”  
 9 and inserting “blood-testing strips, lancets, and blood glu-  
 10 cose monitors”.

11 (e) CONFORMING AMENDMENTS.—

12 (1) ELIMINATION OF COINSURANCE FOR CLIN-  
 13 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs  
 14 (1)(D)(i) and (2)(D)(i) of section 1833(a) (42  
 15 U.S.C. 1395l(a)) are each amended—

16 (A) by striking “basis or which” and in-  
 17 serting “basis, which”; and

18 (B) by inserting “, or which are described  
 19 in subsection (p)” after “critical access hos-  
 20 pital”.

21 (2) ELIMINATION OF COINSURANCE FOR CER-  
 22 TAIN DME.—Section 1834(a)(1)(A) (42 U.S.C.  
 23 1395m(a)(1)(A)) is amended by inserting “(or 100  
 24 percent, in the case of such an item described in sec-  
 25 tion 1833(p))” after “80 percent”.

1           (3) ELIMINATION OF COINSURANCE FOR  
 2       SCREENING MAMMOGRAPHY.—Section 1834(c)(1)(C)  
 3       (42 U.S.C. 1395m(c)(1)(C)) is amended by striking  
 4       “80 percent” and inserting “100 percent”.

5           (4) ELIMINATION OF DEDUCTIBLES AND COIN-  
 6       SURANCE FOR COLORECTAL CANCER SCREENING  
 7       TESTS.—Section 1834(d) (42 U.S.C. 1395m(d)) is  
 8       amended—

9           (A) in paragraph (2)(C)—

10               (i) by striking clause (ii);

11               (ii) by striking “FACILITY PAYMENT  
 12       LIMIT.—” and all that follows through  
 13       “Notwithstanding” and inserting “FACIL-  
 14       ITY PAYMENT LIMIT.—Notwithstanding”;  
 15       and

16               (iii) by redesignating subclauses (I)  
 17       and (II) as clauses (i) and (ii), respec-  
 18       tively; and

19           (B) in paragraph (3)(C)—

20               (i) by striking clause (ii); and

21               (ii) by striking “FACILITY PAYMENT  
 22       LIMIT.—” and all that follows through  
 23       “Notwithstanding” and inserting “FACIL-  
 24       ITY PAYMENT LIMIT.—Notwithstanding”.

1 (f) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to items and services furnished on  
 3 or after July 1, 2001.

4 **SEC. 232. COUNSELING FOR CESSATION OF TOBACCO USE.**

5 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
 6 1395x(s)(2)) is amended—

7 (1) in subparagraph (S), by striking “and” at  
 8 the end;

9 (2) in subparagraph (T), by inserting “and” at  
 10 the end; and

11 (3) by adding at the end the following new sub-  
 12 paragraph:

13 “(U) counseling for cessation of tobacco use (as  
 14 defined in subsection (uu)) for individuals who have  
 15 a history of tobacco use;”.

16 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
 17 1395x) is amended by adding at the end the following new  
 18 subsection:

19 “Counseling for Cessation of Tobacco Use

20 “(uu)(1) Except as provided in paragraph (2), the  
 21 term ‘counseling for cessation of tobacco use’ means diag-  
 22 nostic, therapy, and counseling services for cessation of  
 23 tobacco use which are furnished—

24 “(A) by or under the supervision of a physician;

25 or

1           “(B) by any other health care professional who  
 2           is legally authorized to furnish such services under  
 3           State law (or the State regulatory mechanism pro-  
 4           vided by State law) of the State in which the serv-  
 5           ices are furnished, as would otherwise be covered if  
 6           furnished by a physician or as an incident to a phy-  
 7           sician’s professional service.

8           “(2) The term ‘counseling for cessation of tobacco  
 9           use’ does not include coverage for drugs or biologicals that  
 10          are not otherwise covered under this title.”.

11          (c) ELIMINATION OF COST-SHARING.—

12           (1) ELIMINATION OF COINSURANCE.—Section  
 13          1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by  
 14          section 225(b), is amended—

15                   (A) by striking “and” before “(T)”; and

16                   (B) by inserting before the semicolon at  
 17          the end the following: “, and (U) with respect  
 18          to counseling for cessation of tobacco use (as  
 19          defined in section 1861(uu)), the amount paid  
 20          shall be 100 percent of the lesser of the actual  
 21          charge for the services or the amount deter-  
 22          mined by a fee schedule established by the Sec-  
 23          retary for the purposes of this subparagraph”.



1           (2) ELIMINATION OF DEDUCTIBLE.—The first  
2       sentence of section 1833(b) (42 U.S.C. 1395l(b)) is  
3       amended—

4           (A) by striking “and” before “(6)”; and

5           (B) by inserting before the period the fol-  
6       lowing: “, and (7) such deductible shall not  
7       apply with respect to counseling for cessation of  
8       tobacco use (as defined in section 1861(uu))”.

9       (d) EFFECTIVE DATE.—The amendments made by  
10     this section shall apply to services furnished on or after  
11     July 1, 2001.

12     **SEC. 233. COVERAGE OF GLAUCOMA DETECTION TESTS.**

13       (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x),  
14     as amended by section 232, is amended—

15           (1) in subsection (s)(2)—

16           (A) in subparagraph (T), by striking  
17       “and” at the end;

18           (B) in subparagraph (U), by inserting  
19       “and” at the end; and

20           (C) by adding at the end the following new  
21       subparagraph:

22       “(V) glaucoma detection tests (as defined in  
23       subsection (vv));”; and

24           (2) by adding at the end the following new sub-  
25       section:

1 “Glaucoma Detection Tests

2 “(vv) The term ‘glaucoma detection test’ means all  
3 of the following conducted for the purpose of early detec-  
4 tion of glaucoma:

5 “(1) A dilated eye examination with an intra-  
6 ocular pressure measurement.

7 “(2) Direct ophthalmoscopy or slit-lamp bio-  
8 microscopic examination.”.

9 (b) LIMITATION ON ELIGIBILITY AND FREQUENCY.—  
10 Section 1834 (42 U.S.C. 1395m) is amended by adding  
11 at the end the following new subsection:

12 “(m) LIMITATION ON COVERAGE OF GLAUCOMA DE-  
13TECTION TESTS.—

14 “(1) IN GENERAL.—Notwithstanding any other  
15 provision of this part, with respect to expenses in-  
16 curred for glaucoma detection tests (as defined in  
17 section 1861(vv)), payment may be made only for  
18 glaucoma detection tests conducted—

19 “(A) for individuals described in paragraph  
20 (2); and

21 “(B) consistent with the frequency per-  
22 mitted under paragraph (3).

23 “(2) INDIVIDUALS ELIGIBLE FOR BENEFIT.—  
24 Individuals described in this paragraph are as fol-  
25 lows:

1           “(A) Individuals who are 60 years of age  
2           or older and who have a family history of glau-  
3           coma.

4           “(B) Other individuals who are at high  
5           risk (as determined by the Secretary) of devel-  
6           oping glaucoma.

7           “(3) FREQUENCY LIMIT.—

8           “(A) IN GENERAL.—Subject to subpara-  
9           graph (B), payment may not be made under  
10          this part for a glaucoma detection test per-  
11          formed for an individual within 23 months fol-  
12          lowing the month in which a glaucoma detection  
13          test was performed under this part for the indi-  
14          vidual.

15          “(B) EXCEPTION.—The Secretary may  
16          permit a glaucoma detection test to be covered  
17          on a more frequent basis than that provided  
18          under subparagraph (A) under such cir-  
19          cumstances as the Secretary determines to be  
20          appropriate.”.

21          (c) NO APPLICATION OF DEDUCTIBLE.—Section  
22          1833(b)(5) (42 U.S.C. 1395l(b)(5)) is amended by insert-  
23          ing “or with respect to glaucoma detection tests (as de-  
24          fined in section 1861(vv))” after “1861(jj))”.

1 (d) CONFORMING AMENDMENTS.—Section 1862(a)  
 2 (42 U.S.C. 1395y(a)) is amended—

3 (1) in paragraph (1)—

4 (A) in subparagraph (H), by striking  
 5 “and” at the end;

6 (B) in subparagraph (I), by striking the  
 7 semicolon at the end and inserting “, and”; and

8 (C) by adding at the end the following new  
 9 subparagraph:

10 “(J) in the case of glaucoma detection tests (as  
 11 defined in section 1861(vv)), which are furnished to  
 12 an individual not described in paragraph (2) of sec-  
 13 tion 1834(m) or which are performed more fre-  
 14 quently than is covered under paragraph (3) of such  
 15 section;”; and

16 (2) in paragraph (7), by striking “or (H)” and  
 17 inserting “(H), or (I)”.

18 (e) EFFECTIVE DATE.—The amendments made by  
 19 this section apply to tests provided on or after July 1,  
 20 2001.

21 **SEC. 234. MEDICAL NUTRITION THERAPY SERVICES FOR**  
 22 **BENEFICIARIES WITH DIABETES, A CARDIO-**  
 23 **VASCULAR DISEASE, OR A RENAL DISEASE.**

24 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
 25 1395x(s)(2)), as amended by section 233(a), is amended—

1           (1) in subparagraph (U) by striking “and” at  
2     the end;

3           (2) in subparagraph (V) by inserting “and” at  
4     the end; and

5           (3) by adding at the end the following new sub-  
6     paragraph:

7           “(W) medical nutrition therapy services (as de-  
8     fined in subsection (ww)(1)) in the case of a bene-  
9     ficiary with diabetes, a cardiovascular disease (in-  
10    cluding congestive heart failure, arteriosclerosis,  
11    hyperlipidemia, hypertension, and hypercholester-  
12    olemia), or a renal disease;”.

13       (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
14   1395x), as amended by section 233(a), is amended by add-  
15   ing at the end the following new subsection:

16       “Medical Nutrition Therapy Services; Registered  
17               Dietitian or Nutrition Professional

18       “(ww)(1) The term ‘medical nutrition therapy serv-  
19    ices’ means nutritional diagnostic, therapy, and counseling  
20    services for the purpose of disease management which are  
21    furnished by a registered dietitian or nutrition profes-  
22    sional (as defined in paragraph (2)) pursuant to a referral  
23    by a physician (as defined in subsection (r)(1)).

1       “(2) Subject to paragraph (3), the term ‘registered  
2 dietitian or nutrition professional’ means an individual  
3 who—

4               “(A) holds a baccalaureate or higher degree  
5 granted by a regionally accredited college or univer-  
6 sity in the United States (or an equivalent foreign  
7 degree) with completion of the academic require-  
8 ments of a program in nutrition or dietetics, as ac-  
9 credited by an appropriate national accreditation or-  
10 ganization recognized by the Secretary for this pur-  
11 pose;

12              “(B) has completed at least 900 hours of super-  
13 vised dietetics practice under the supervision of a  
14 registered dietitian or nutrition professional; and

15              “(C)(i) is licensed or certified as a dietitian or  
16 nutrition professional by the State in which the serv-  
17 ices are performed; or

18              “(ii) in the case of an individual in a State that  
19 does not provide for such licensure or certification,  
20 meets such other criteria as the Secretary estab-  
21 lishes.

22       “(3) Subparagraphs (A) and (B) of paragraph (2)  
23 shall not apply in the case of an individual who, as of the  
24 date of enactment of this subsection, is licensed or cer-  
25 tified as a dietitian or nutrition professional by the State

1 in which medical nutrition therapy services are per-  
 2 formed.”.

3 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.  
 4 1395l(a)(1)), as amended by section 232(c)(1), is  
 5 amended—

6 (1) by striking “and” before “(U)”; and

7 (2) by inserting before the semicolon at the end  
 8 the following: “, and (V) with respect to medical nu-  
 9 trition therapy services (as defined in section  
 10 1861(w)), the amount paid shall be 85 percent of  
 11 the lesser of the actual charge for the services or the  
 12 amount determined under the fee schedule estab-  
 13 lished under section 1848(b) for the same services if  
 14 furnished by a physician”.

15 (d) EFFECTIVE DATE.—The amendments made by  
 16 this section apply to services furnished on or after July  
 17 1, 2001.

18 **SEC. 235. STUDIES ON PREVENTIVE INTERVENTIONS IN**  
 19 **PRIMARY CARE FOR OLDER AMERICANS.**

20 (a) STUDIES.—The Secretary of Health and Human  
 21 Services, acting through the United States Preventive  
 22 Services Task Force, shall conduct a series of studies de-  
 23 signed to identify preventive interventions that can be de-  
 24 livered in the primary care setting that are most valuable  
 25 to older Americans.

1 (b) MISSION STATEMENT.—The mission statement of  
 2 the United States Preventive Services Task Force is  
 3 amended to include the evaluation of services that are of  
 4 particular relevance to older Americans.

5 (c) REPORT.—Not later than 1 year after the date  
 6 of enactment of this Act, and annually thereafter, the Sec-  
 7 retary of Health and Human Services shall submit a re-  
 8 port to Congress on the conclusions of the studies con-  
 9 ducted under subsection (a), together with recommenda-  
 10 tions for such legislation and administrative actions as the  
 11 Secretary considers appropriate.

12 **SEC. 236. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PRE-**  
 13 **VENTION BENEFIT STUDY AND REPORT.**

14 (a) STUDY.—

15 (1) IN GENERAL.—The Secretary of Health and  
 16 Human Services shall contract with the Institute of  
 17 Medicine of the National Academy of Sciences to  
 18 conduct a comprehensive study of current literature  
 19 and best practices in the field of health promotion  
 20 and disease prevention among medicare beneficiaries  
 21 including the issues described in paragraph (2) and  
 22 to submit the report described in subsection (b).

23 (2) ISSUES STUDIED.—The study required  
 24 under paragraph (1) shall include an assessment  
 25 of—



1 (A) whether each covered benefit is—

2 (i) medically effective; and

3 (ii) a cost-effective benefit or a cost-  
4 saving benefit;

5 (B) utilization of covered benefits (includ-  
6 ing any barriers to or incentives to increase uti-  
7 lization); and

8 (C) quality of life issues associated with  
9 both health promotion and disease prevention  
10 benefits covered under the medicare program  
11 and those that are not covered under such pro-  
12 gram that would affect all medicare bene-  
13 ficiaries.

14 (b) REPORT.—

15 (1) IN GENERAL.—Not later than 5 years after  
16 the date of enactment of this section, and every fifth  
17 year thereafter, the Institute of Medicine of the Na-  
18 tional Academy of Sciences shall submit to the  
19 President a report that contains a detailed state-  
20 ment of the findings and conclusions of the study  
21 conducted under subsection (a) and the rec-  
22 ommendations for legislation described in paragraph  
23 (2).

24 (2) RECOMMENDATIONS FOR LEGISLATION.—

25 The Institute of Medicine of the National Academy

1 of Sciences, in consultation with the Partnership for  
2 Prevention, shall develop recommendations in legis-  
3 lative form that—

4 (A) prioritize the preventive benefits under  
5 the medicare program; and

6 (B) modify preventive benefits offered  
7 under the medicare program based on the study  
8 conducted under subsection (a).

9 (c) TRANSMISSION TO CONGRESS.—

10 (1) IN GENERAL.—On the day on which the re-  
11 port described in subsection (b) is submitted to the  
12 President, the President shall transmit the report  
13 and recommendations in legislative form described in  
14 subsection (b)(2) to Congress.

15 (2) DELIVERY.—Copies of the report and rec-  
16 ommendations in legislative form required to be  
17 transmitted to Congress under paragraph (1) shall  
18 be delivered—

19 (A) to both Houses of Congress on the  
20 same day;

21 (B) to the Clerk of the House of Rep-  
22 resentatives if the House is not in session; and

23 (C) to the Secretary of the Senate if the  
24 Senate is not in session.

25 (d) DEFINITIONS.—In this section:

1           (1) COST-EFFECTIVE BENEFIT.—The term  
2           “cost-effective benefit” means a benefit or technique  
3           that has—

4                   (A) been subject to peer review;

5                   (B) been described in scientific journals;

6           and

7                   (C) demonstrated value as measured by  
8           unit costs relative to health outcomes achieved.

9           (2) COST-SAVING BENEFIT.—The term “cost-  
10          saving benefit” means a benefit or technique that  
11          has—

12                   (A) been subject to peer review;

13                   (B) been described in scientific journals;

14          and

15                   (C) caused a net reduction in health care  
16          costs for medicare beneficiaries.

17          (3) MEDICALLY EFFECTIVE.—The term “medi-  
18          cally effective” means, with respect to a benefit or  
19          technique, that the benefit or technique has been—

20                   (A) subject to peer review;

21                   (B) described in scientific journals; and

22                   (C) determined to achieve an intended goal  
23          under normal programmatic conditions.

24          (4) MEDICARE BENEFICIARY.—The term  
25          “medicare beneficiary” means any individual who is

1 entitled to benefits under part A or enrolled under  
 2 part B of the medicare program, including any indi-  
 3 vidual enrolled in a Medicare+Choice plan offered  
 4 by a Medicare+Choice organization under part C of  
 5 such program.

6 (5) MEDICARE PROGRAM.—The term “medicare  
 7 program” means the health benefits program under  
 8 title XVIII of the Social Security Act (42 U.S.C.  
 9 1395 et seq.).

10 **SEC. 237. FAST-TRACK CONSIDERATION OF PREVENTION**  
 11 **BENEFIT LEGISLATION.**

12 (a) RULES OF HOUSE OF REPRESENTATIVES AND  
 13 SENATE.—This section is enacted by Congress—

14 (1) as an exercise of the rulemaking power of  
 15 the House of Representatives and the Senate, re-  
 16 spectively, and is deemed a part of the rules of each  
 17 House of Congress, but—

18 (A) is applicable only with respect to the  
 19 procedure to be followed in that House of Con-  
 20 gress in the case of an implementing bill (as de-  
 21 fined in subsection (d)); and

22 (B) supersedes other rules only to the ex-  
 23 tent that such rules are inconsistent with this  
 24 section; and

1           (2) with full recognition of the constitutional  
2 right of either House of Congress to change the  
3 rules (so far as relating to the procedure of that  
4 House of Congress) at any time, in the same man-  
5 ner and to the same extent as in the case of any  
6 other rule of that House of Congress.

7           (b) INTRODUCTION AND REFERRAL.—

8           (1) INTRODUCTION.—

9           (A) IN GENERAL.—Subject to paragraph  
10 (2), on the day on which the President trans-  
11 mits the report pursuant to section 236(c) to  
12 the House of Representatives and the Senate,  
13 the recommendations in legislative form trans-  
14 mitted by the President with respect to such re-  
15 port shall be introduced as a bill (by request)  
16 in the following manner:

17           (i) HOUSE OF REPRESENTATIVES.—In  
18 the House of Representatives, by the Ma-  
19 jority Leader, for himself and the Minority  
20 Leader, or by Members of the House of  
21 Representatives designated by the Majority  
22 Leader and Minority Leader.

23           (ii) SENATE.—In the Senate, by the  
24 Majority Leader, for himself and the Mi-  
25 nority Leader, or by Members of the Sen-

1                   ate designated by the Majority Leader and  
2                   Minority Leader.

3                   (B) SPECIAL RULE.—If either House of  
4                   Congress is not in session on the day on which  
5                   such recommendations in legislative form are  
6                   transmitted, the recommendations in legislative  
7                   form shall be introduced as a bill in that House  
8                   of Congress, as provided in subparagraph (A),  
9                   on the first day thereafter on which that House  
10                  of Congress is in session.

11                (2) REFERRAL.—Such bills shall be referred by  
12                the presiding officers of the respective Houses to the  
13                appropriate committee, or, in the case of a bill con-  
14                taining provisions within the jurisdiction of 2 or  
15                more committees, jointly to such committees for con-  
16                sideration of those provisions within their respective  
17                jurisdictions.

18                (c) CONSIDERATION.—After the recommendations in  
19                legislative form have been introduced as a bill and referred  
20                under subsection (b), such implementing bill shall be con-  
21                sidered in the same manner as an implementing bill is con-  
22                sidered under subsections (d), (e), (f), and (g) of section  
23                151 of the Trade Act of 1974 (19 U.S.C. 2191).

24                (d) IMPLEMENTING BILL DEFINED.—In this section,  
25                the term “implementing bill” means only the recommenda-

1 tions in legislative form of the Institute of Medicine of the  
 2 National Academy of Sciences described in section  
 3 236(b)(2), transmitted by the President to the House of  
 4 Representatives and the Senate under section 236(c), and  
 5 introduced and referred as provided in subsection (b) as  
 6 a bill of either House of Congress.

7 (e) COUNTING OF DAYS.—For purposes of this sec-  
 8 tion, any period of days referred to in section 151 of the  
 9 Trade Act of 1974 shall be computed by excluding—

10 (1) the days on which either House of Congress  
 11 is not in session because of an adjournment of more  
 12 than 3 days to a day certain or an adjournment of  
 13 Congress sine die; and

14 (2) any Saturday and Sunday, not excluded  
 15 under paragraph (1), when either House is not in  
 16 session.

## 17 **Subtitle E—Other Services**

### 18 **SEC. 241. REVISION OF MORATORIUM IN CAPS FOR THER-** 19 **APY SERVICES.**

20 (a) EXTENSION OF MORATORIUM.—Section  
 21 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by strik-  
 22 ing “during 2000 and 2001” and inserting “during the  
 23 period beginning on January 1, 2000, and ending on the  
 24 date that is 18 months after the date the Secretary sub-

1 mits the report required under section 4541(d)(2) of the  
2 Balanced Budget Act of 1997 to Congress”.

3 (b) EXTENSION OF REPORTING DATE.—Section  
4 4541(d)(2) of BBA (42 U.S.C. 1395l note), as amended  
5 by section 221(c) of BBRA (113 Stat. 1501A–351), is  
6 amended by striking “January 1, 2001” and inserting  
7 “January 1, 2002”.

8 **SEC. 242. REVISION OF COVERAGE OF IMMUNO-**  
9 **SUPPRESSIVE DRUGS.**

10 (a) REVISION.—

11 (1) IN GENERAL.—Section 1861(s)(2)(J) (42  
12 U.S.C. 1395x(s)(2)(J)) is amended to read as fol-  
13 lows:

14 “(J) prescription drugs used in immuno-  
15 suppressive therapy furnished—

16 “(i) on or after the date of enactment of  
17 the Medicare, Medicaid, and SCHIP Balanced  
18 Budget Refinement Act of 2000 and before  
19 January 1, 2004, to an individual who has re-  
20 ceived an organ transplant; and

21 “(ii) on or after January 1, 2004, to an in-  
22 dividual who receives an organ transplant for  
23 which payment is made under this title, but  
24 only in the case of drugs furnished within 36



1 months after the date of the transplant proce-  
2 dure.”.

3 (2) CONFORMING AMENDMENTS.—

4 (A) EXTENDED COVERAGE.—Section 1832  
5 (42 U.S.C. 1395k) is amended—

6 (i) by striking subsection (b); and

7 (ii) by redesignating subsection (c) as  
8 subsection (b).

9 (B) PASS-THROUGH; REPORT.—Sub-  
10 sections (c) and (d) of section 227 of BBRA  
11 (113 Stat. 1501A–355) are repealed.

12 (3) EFFECTIVE DATE.—The amendments made  
13 by this subsection shall apply to drugs furnished on  
14 or after the date of enactment of this Act.

15 (b) EXTENSION OF CERTAIN SECONDARY PAYER RE-  
16 QUIREMENTS.—Section 1862(b)(1)(C) (42 U.S.C.  
17 1395y(b)(1)(C)) is amended by adding at the end the fol-  
18 lowing: “With regard to immunosuppressive drugs fur-  
19 nished on or after the date of enactment of the Medicare,  
20 Medicaid, and SCHIP Balanced Budget Refinement Act  
21 of 2000 and before January 1, 2004, this subparagraph  
22 shall be applied without regard to any time limitation.”.

1 **SEC. 243. STATE ACCREDITATION OF DIABETES SELF-MAN-**  
 2 **AGEMENT TRAINING PROGRAMS.**

3 Section 1861(qq)(2) of the Social Security Act (42  
 4 U.S.C. 1395xx(qq)(2)) is amended—

5 (1) in the matter preceding subparagraph (A),  
 6 by striking “paragraph (1)—” and inserting “para-  
 7 graph (1):”;

8 (2) in subparagraph (A)—

9 (A) by striking “a ‘certified provider’” and  
 10 inserting “A ‘certified provider’”; and

11 (B) by striking “; and” and inserting a pe-  
 12 riod; and

13 (3) in subparagraph (B)—

14 (A) by striking “a physician, or such other  
 15 individual” and inserting “(i) A physician, or  
 16 such other individual”;

17 (B) by inserting “(I)” before “meets appli-  
 18 cable standards”;

19 (C) by inserting “(II)” before “is recog-  
 20 nized”;

21 (D) by inserting “, or by a program de-  
 22 scribed in clause (ii),” after “recognized by an  
 23 organization that represents individuals (includ-  
 24 ing individuals under this title) with diabetes”;  
 25 and

1 (E) by adding at the end the following new  
 2 clause:

3 “(ii) Notwithstanding any reference to ‘a na-  
 4 tional accreditation body’ in section 1865(b), for  
 5 purposes of clause (i), a program described in this  
 6 clause is a program operated by a State for the pur-  
 7 poses of accrediting diabetes self-management train-  
 8 ing programs, if the Secretary determines that such  
 9 State program has established quality standards  
 10 that meet or exceed the standards established by the  
 11 Secretary under clause (i) or the standards origi-  
 12 nally established by the National Diabetes Advisory  
 13 Board and subsequently revised as described in  
 14 clause (i).”.

15 **SEC. 244. ELIMINATION OF REDUCTION IN PAYMENT**  
 16 **AMOUNTS FOR DURABLE MEDICAL EQUIP-**  
 17 **MENT AND OXYGEN AND OXYGEN EQUIP-**  
 18 **MENT.**

19 (a) UPDATE FOR COVERED ITEMS.—Section  
 20 1834(a)(14)(C) (42 U.S.C. 1395m(a)(14)(C)) is amended  
 21 by striking “through 2002” and inserting “through  
 22 2000”.

23 (b) ORTHOTICS AND PROSTHETICS.—Section  
 24 1834(h)(4)(A)(v) (42 U.S.C. 1395m(h)(4)(A)(v)) is

1 amended by striking “through 2002” and inserting  
 2 “through 2000”.

3 (c) PARENTERAL AND ENTERAL NUTRIENTS, SUP-  
 4 PLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42  
 5 U.S.C. 1395m note) is amended by striking “through  
 6 2002” and inserting “through 2000”.

7 (d) OXYGEN AND OXYGEN EQUIPMENT.—Section  
 8 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

9 (1) in clause (v), by striking “and” at the end;

10 (2) in clause (vi)—

11 (A) by striking “each subsequent year”  
 12 and inserting “2000”; and

13 (B) by striking the period at the end and  
 14 inserting “; and”; and

15 (3) by adding at the end the following new  
 16 clause:

17 “(vii) for 2001 and each subsequent  
 18 year, the amount determined under this  
 19 subparagraph for the preceding year in-  
 20 creased by the covered item update for  
 21 such subsequent year.”.

22 (e) CONFORMING AMENDMENT.—Section 228 of  
 23 BBRA (113 Stat. 1501A–356) is repealed.

1 **SEC. 245. STANDARDS REGARDING PAYMENT FOR CERTAIN**  
 2 **ORTHOTICS AND PROSTHETICS.**

3 (a) STANDARDS.—

4 (1) IN GENERAL.—Section 1834(h)(1) (42  
 5 U.S.C. 1395m(h)(1)) is amended by adding at the  
 6 end the following:

7 “(F) ESTABLISHMENT OF STANDARDS FOR  
 8 CERTAIN ITEMS.—

9 “(i) IN GENERAL.—No payment shall  
 10 be made for an applicable item unless such  
 11 item is provided by a qualified practitioner  
 12 or a qualified supplier under the system es-  
 13 tablished by the Secretary under clause  
 14 (iii). For purposes of the preceding sen-  
 15 tence, if a qualified practitioner or a quali-  
 16 fied supplier contracts with an entity to  
 17 provide an applicable item, then no pay-  
 18 ment shall be made for such item unless  
 19 the entity is also a qualified supplier.

20 “(ii) DEFINITIONS.—In this  
 21 subparagraph—

22 “(I) APPLICABLE ITEM.—The  
 23 term ‘applicable item’ means orthotics  
 24 and prosthetics that require edu-  
 25 cation, training, and experience to  
 26 custom fabricate such item. Such

1 term does not include shoes and shoe  
2 inserts.

3 “(II) QUALIFIED PRACTI-  
4 TIONER.—The term ‘qualified practi-  
5 tioner’ means a physician or health  
6 professional who meets any of the fol-  
7 lowing requirements:

8 “(aa) The physician or  
9 health professional is specifically  
10 trained and educated to provide  
11 or manage the provision of cus-  
12 tom-designed, fabricated, modi-  
13 fied, and fitted orthotics and  
14 prosthetics, and is either certified  
15 by the American Board for Cer-  
16 tification in Orthotics and Pros-  
17 thetics, Inc., certified by the  
18 Board for Orthotist/Prosthetist  
19 Certification, or credentialed and  
20 approved by a program that the  
21 Secretary determines, in con-  
22 sultation with appropriate ex-  
23 perts in orthotics and prosthetics,  
24 has training and education stand-

1           ards that are necessary to pro-  
2           vide applicable items.

3                   “(bb)   The   physician   or  
4           health professional is licensed in  
5           orthotics or prosthetics by the  
6           State in which the applicable  
7           item is supplied, but only if the  
8           Secretary determines that the  
9           mechanisms used by the State to  
10          provide such licensure meet  
11          standards determined appropriate  
12          by the Secretary.

13                   “(cc)   The   physician   or  
14          health professional has completed  
15          at least 10 years practice in the  
16          provision of applicable items. A  
17          physician or health professional  
18          may not qualify as a qualified  
19          practitioner under the preceding  
20          sentence with respect to an appli-  
21          cable item if the item was pro-  
22          vided on or after January 1,  
23          2005.

1 “(III) QUALIFIED SUPPLIER.—

2 The term ‘qualified supplier’ means  
3 any entity that is—

4 “(aa) accredited by the  
5 American Board for Certification  
6 in Orthotics and Prosthetics, Inc.  
7 or the Board for Orthotist/Pros-  
8 thetist Certification; or

9 “(bb) accredited and ap-  
10 proved by a program that the  
11 Secretary determines has accredi-  
12 tation and approval standards  
13 that are essentially equivalent to  
14 those of such Board.

15 “(iii) SYSTEM.—The Secretary, in  
16 consultation with appropriate experts in  
17 orthotics and prosthetics, shall establish a  
18 system under which the Secretary shall—

19 “(I) determine which items are  
20 applicable items and formulate a list  
21 of such items;

22 “(II) review the applicable items  
23 billed under the coding system estab-  
24 lished under this title; and



1 “(III) limit payment for applica-  
2 ble items pursuant to clause (i).”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by paragraph (1) shall apply to items provided on or  
5 after January 1, 2003.

6 (b) REVISION OF DEFINITION OF ORTHOTICS.—

7 (1) IN GENERAL.—Section 1861(s)(9) (42  
8 U.S.C. 1395x(s)(9)) is amended by inserting “(in-  
9 cluding such braces that are used in conjunction  
10 with, or as components of, other medical or non-  
11 medical equipment when provided by a qualified  
12 practitioner (as defined in subclause (II) of section  
13 1834(h)(1)(F))) or a qualified supplier (as defined  
14 in subclause (III) of such section)” after “braces”.

15 (2) EFFECTIVE DATE.—The amendment made  
16 by paragraph (1) shall apply to items provided on or  
17 after January 1, 2003.

18 **SEC. 246. NATIONAL LIMITATION AMOUNT EQUAL TO 100**  
19 **PERCENT OF NATIONAL MEDIAN FOR NEW**  
20 **PAP SMEAR TECHNOLOGIES AND OTHER NEW**  
21 **CLINICAL LABORATORY TEST TECH-**  
22 **NOLOGIES.**

23 Section 1833(h)(4)(B)(viii) (42 U.S.C.  
24 1395l(h)(4)(B)(viii)) is amended by inserting before the  
25 period at the end the following: “(or 100 percent of such

1 median in the case of a clinical diagnostic laboratory test  
 2 performed on or after January 1, 2001, that the Secretary  
 3 determines is a new test for which no limitation amount  
 4 has previously been established under this subpara-  
 5 graph)’’.

6 **SEC. 247. INCREASED MEDICARE PAYMENTS FOR CER-**  
 7 **TIFIED NURSE-MIDWIFE SERVICES.**

8 (a) AMOUNT OF PAYMENT.—Section 1833(a)(1)(K)  
 9 (42 U.S.C. 1395l(a)(1)(K)) is amended by striking “65  
 10 percent of the prevailing charge that would be allowed for  
 11 the same service performed by a physician, or, for services  
 12 furnished on or after January 1, 1992, 65 percent” and  
 13 inserting “85 percent”.

14 (b) EFFECTIVE DATE.—The amendment made by  
 15 subsection (a) shall apply to services furnished on or after  
 16 January 1, 2001.

17 **SEC. 248. PAYMENT FOR ADMINISTRATION OF DRUGS.**

18 (a) REVIEW OF CHEMOTHERAPY ADMINISTRATION  
 19 PRACTICE EXPENSES RVUS.—The Secretary of Health  
 20 and Human Services shall review the resource-based prac-  
 21 tice expense component of relative value units under the  
 22 physician fee schedule under section 1848 of the Social  
 23 Security Act (42 U.S.C. 1395w–4) for chemotherapy ad-  
 24 ministration services to determine if such units should be  
 25 increased.

1 (b) MORE ACCURATE CHEMOTHERAPY DRUG PAY-  
 2 MENTS TIED TO INCREASES IN CHEMOTHERAPY ADMINIS-  
 3 TRATION PAYMENTS.—If the Secretary of Health and  
 4 Human Services determines, as a result of the review  
 5 under subsection (a), that the resource-based practice ex-  
 6 pense relative value units for chemotherapy administration  
 7 services should be increased, the Secretary—

8 (1) may implement such increases for such  
 9 services, but only if the Secretary simultaneously im-  
 10 plements more accurate average wholesale prices for  
 11 chemotherapy drugs (but in no case shall such si-  
 12 multaneous implementation occur prior to January  
 13 1, 2002); and

14 (2) if the Secretary implements such increases  
 15 for such services, shall do so without taking into ac-  
 16 count the requirement under the physician fee  
 17 schedule under section 1848(c)(2)(B)(ii)(II) of the  
 18 Social Security Act (42 U.S.C. 1395w-  
 19 4(c)(2)(B)(ii)(II)).

20 (c) BLOOD CLOTTING DRUG-RELATED ACTIVI-  
 21 TIES.—

22 (1) COVERAGE.—Section 1861(s)(2)(I) (42  
 23 U.S.C. 1395x(s)(2)(I)) is amended—

24 (A) by striking “and” after “supervision,”;  
 25 and

1 (B) by inserting the following before the  
 2 semicolon: “, and the costs (pursuant to section  
 3 1834(n)) incurred by suppliers of such factors”.

4 (2) PAYMENTS.—Section 1834 (42 U.S.C.  
 5 1395m), as amended by section 233(b), is amended  
 6 by adding at the end the following new subsection:  
 7 “(n) PAYMENT FOR BLOOD CLOTTING DRUG-RE-  
 8 LATED ACTIVITIES.—

9 “(1) IN GENERAL.—The Secretary shall make  
 10 payments in accordance with paragraph (2) to sup-  
 11 pliers of blood clotting factors (as described in sec-  
 12 tion 1861(s)(2)(I)) to cover the costs (such as ship-  
 13 ping, storage, inventory control, or other costs speci-  
 14 fied by the Secretary) incurred by such suppliers in  
 15 furnishing such factors to individuals enrolled under  
 16 this part.

17 “(2) PAYMENT AMOUNT.—The amount of pay-  
 18 ment for furnishing such blood clotting factors (as  
 19 so described) shall be an amount equal to 80 percent  
 20 of the lesser of—

21 “(A) the actual charge for the furnishing  
 22 of such factors; or

23 “(B) an amount equal to 10 cents (or such  
 24 other amount determined appropriate by the  
 25 Secretary) per unit of such factor furnished.”.

1           (3) EFFECTIVE DATE.—The amendments made  
2       by this subsection shall apply to blood clotting fac-  
3       tors (as described in section 1861(s)(2)(I) of the So-  
4       cial Security Act (42 U.S.C. 1395x(s)(2)(I))) fur-  
5       nished on or after the date that the Secretary of  
6       Health and Human Services implements more accu-  
7       rate average wholesale prices for such factors.

8   **SEC. 249. MEDPAC STUDY ON IN-HOME INFUSION THERAPY**  
9                           **NURSING SERVICES.**

10       (a) STUDY.—The Medicare Payment Advisory Com-  
11      mission established under section 1805 of the Social Secu-  
12      rity Act (42 U.S.C. 1395b–6) (in this section referred to  
13      as “MedPAC”) shall conduct a study on the provision of  
14      in-home infusion therapy nursing services, including a re-  
15      view of any documentation of clinical efficacy for those  
16      services and any costs associated with providing those  
17      services.

18       (b) REPORT.—Not later than 18 months after the  
19      date of enactment of this Act, MedPAC shall submit a  
20      report to the Secretary of Health and Human Services and  
21      Congress on the study and review conducted under sub-  
22      section (a) together with recommendations regarding the  
23      establishment of a payment methodology for in-home infu-  
24      sion therapy nursing services that ensures the continuing  
25      access of beneficiaries under the medicare program under

1 title XVIII of the Social Security Act (42 U.S.C. 1395  
2 et seq.) to those services.

3 **TITLE III—PROVISIONS**  
4 **RELATING TO PARTS A AND B**  
5 **Subtitle A—Home Health Services**

6 **SEC. 301. ELIMINATION OF 15 PERCENT REDUCTION IN**  
7 **PAYMENT RATES UNDER THE PROSPECTIVE**  
8 **PAYMENT SYSTEM FOR HOME HEALTH SERV-**  
9 **ICES.**

10 (a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C.  
11 1395fff(b)(3)(A)) is amended to read as follows:

12 “(A) INITIAL BASIS.—Under such system  
13 the Secretary shall provide for computation of  
14 a standard prospective payment amount (or  
15 amounts). Such amount (or amounts) shall ini-  
16 tially be based on the most current audited cost  
17 report data available to the Secretary and shall  
18 be computed in a manner so that the total  
19 amounts payable under the system for the 12-  
20 month period beginning on the date the Sec-  
21 retary implements the system shall be equal to  
22 the total amount that would have been made if  
23 the system had not been in effect and if section  
24 1861(v)(1)(L)(ix) had not been enacted. Each  
25 such amount shall be standardized in a manner

1           that eliminates the effect of variations in rel-  
 2           ative case mix and area wage adjustments  
 3           among different home health agencies in a  
 4           budget neutral manner consistent with the case  
 5           mix and wage level adjustments provided under  
 6           paragraph (4)(A). Under the system, the Sec-  
 7           retary may recognize regional differences or dif-  
 8           ferences based upon whether or not the services  
 9           or agency are in an urbanized area.”.

10       (b) EFFECTIVE DATE.—The amendment made by  
 11       subsection (a) shall take effect as if included in the enact-  
 12       ment of BBRA.

13       **SEC. 302. EXCLUSION OF CERTAIN NONROUTINE MEDICAL**  
 14                               **SUPPLIES UNDER THE PPS FOR HOME**  
 15                               **HEALTH SERVICES.**

16       (a) EXCLUSION.—

17           (1) IN GENERAL.—Section 1895 (42 U.S.C.  
 18       1395fff) is amended by adding at the end the fol-  
 19       lowing new subsection:

20       “(e) EXCLUSION OF NONROUTINE MEDICAL SUP-  
 21       PLIES.—

22           “(1) IN GENERAL.—Notwithstanding the pre-  
 23       ceding provisions of this section, in the case of all  
 24       nonroutine medical supplies (as defined by the Sec-  
 25       retary) furnished by a home health agency during a

1 year (beginning with 2001) for which payment is  
 2 otherwise made on the basis of the prospective pay-  
 3 ment amount under this section, payment under this  
 4 section shall be based instead on the lesser of—

5 “(A) the actual charge for the nonroutine  
 6 medical supply; or

7 “(B) the amount determined under the fee  
 8 schedule established by the Secretary for pur-  
 9 poses of making payment for such items under  
 10 part B for nonroutine medical supplies fur-  
 11 nished during that year.

12 “(2) BUDGET NEUTRALITY ADJUSTMENT.—The  
 13 Secretary shall provide for an appropriate propor-  
 14 tional reduction in payments under this section so  
 15 that beginning with fiscal year 2001, the aggregate  
 16 amount of such reductions is equal to the aggregate  
 17 increase in payments attributable to the exclusion ef-  
 18 fected under paragraph (1).”.

19 (2) CONFORMING AMENDMENT.—Section  
 20 1895(b)(1) of the Social Security Act (42 U.S.C.  
 21 1395fff(b)(1)) is amended by striking “The Sec-  
 22 retary” and inserting “Subject to subsection (e), the  
 23 Secretary”.



1           (3) EFFECTIVE DATE.—The amendments made  
2           by this subsection shall apply to supplies furnished  
3           on or after January 1, 2001.

4           (b) EXCLUSION FROM CONSOLIDATED BILLING.—

5           (1) IN GENERAL.—For items provided during  
6           the applicable period, the Secretary of Health and  
7           Human Services shall administer the medicare pro-  
8           gram under title XVIII of the Social Security Act  
9           (42 U.S.C. 1395 et seq.) as if—

10                   (A) section 1842(b)(6)(F) of such Act (42  
11                   U.S.C. 1395u(b)(6)(F)) was amended by strik-  
12                   ing “(including medical supplies described in  
13                   section 1861(m)(5), but excluding durable med-  
14                   ical equipment to the extent provided for in  
15                   such section)” and inserting “(excluding med-  
16                   ical supplies and durable medical equipment de-  
17                   scribed in section 1861(m)(5))”; and

18                   (B) section 1862(a)(21) of such Act (42  
19                   U.S.C. 1395y(a)(21)) was amended by striking  
20                   “(including medical supplies described in sec-  
21                   tion 1861(m)(5), but excluding durable medical  
22                   equipment to the extent provided for in such  
23                   section)” and inserting “(excluding medical  
24                   supplies and durable medical equipment de-  
25                   scribed in section 1861(m)(5))”.

1           (2) APPLICABLE PERIOD DEFINED.—For pur-  
 2           poses of paragraph (1), the term “applicable period”  
 3           means the period beginning on January 1, 2001,  
 4           and ending on the later of—

5                     (A) the date that is 18 months after the  
 6                     date of enactment of this Act; or

7                     (B) the date determined appropriate by the  
 8                     Secretary of Health and Human Services.

9           (c) STUDY ON EXCLUSION OF CERTAIN NONROUTINE  
 10          MEDICAL SUPPLIES UNDER THE PPS FOR HOME  
 11          HEALTH SERVICES.—

12           (1) STUDY.—The Secretary of Health and  
 13          Human Services (in this subsection referred to as  
 14          the “Secretary”) shall conduct a study to identify  
 15          any nonroutine medical supply that may be appro-  
 16          priately and cost-effectively excluded from the pro-  
 17          spective payment system for home health services  
 18          under section 1895 of the Social Security Act (42  
 19          U.S.C. 1395fff). Specifically, the Secretary shall  
 20          consider whether wound care and ostomy supplies  
 21          should be excluded from such prospective payment  
 22          system.

23           (2) REPORT.—Not later than 18 months after  
 24          the date of enactment of this Act, the Secretary  
 25          shall submit to the committees of jurisdiction of the

1 House of Representatives and the Senate a report on  
 2 the study conducted under paragraph (1), including  
 3 a list of any nonroutine medical supplies that should  
 4 be excluded from the prospective payment system for  
 5 home health services under section 1895 of the So-  
 6 cial Security Act (42 U.S.C. 1395fff).

7 (d) EXCLUSION OF OTHER NONROUTINE MEDICAL  
 8 SUPPLIES.—Upon submission of the report under sub-  
 9 section (c)(2), the Secretary shall (if necessary) revise the  
 10 definition of nonroutine medical supply, as defined for  
 11 purposes of section 1895(e) (as added by subsection (a)),  
 12 based on the list of nonroutine medical supplies included  
 13 in such report.

14 **SEC. 303. PERMITTING HOME HEALTH PATIENTS WITH ALZ-**  
 15 **HEIMER’S DISEASE OR A RELATED DEMENTIA**  
 16 **TO ATTEND ADULT DAY-CARE.**

17 (a) IN GENERAL.—Sections 1814(a) and 1835(a) of  
 18 the Social Security Act (42 U.S.C. 1395f(a); 1395n(a))  
 19 are each amended in the last sentence by inserting “(in-  
 20 cluding regularly participating, for the purpose of thera-  
 21 peutic treatment for Alzheimer’s disease or a related de-  
 22 mentia, in an adult day-care program that is licensed, cer-  
 23 tified, or accredited by a State to furnish adult day-care  
 24 services in the State)” before the period.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 subsection (a) shall apply to items and services provided  
 3 on or after October 1, 2001.

4 **SEC. 304. STANDARDS FOR HOME HEALTH BRANCH OF-**  
 5 **FICES.**

6 (a) IN GENERAL.—Section 1861(o) (42 U.S.C.  
 7 1395x(o)) is amended by adding at the end the following  
 8 new sentences: “For purposes of this subsection, a home  
 9 health agency may provide services through a single site  
 10 or through a branch office. For purposes of the preceding  
 11 sentence, the term ‘branch office’ means a service site for  
 12 home health services that is controlled and supervised by  
 13 a home health agency.”.

14 (b) ESTABLISHMENT OF STANDARDS.—

15 (1) IN GENERAL.—The Secretary of Health and  
 16 Human Services (in this subsection referred to as  
 17 the “Secretary”) shall establish, using a negotiated  
 18 rulemaking process under subchapter III of chapter  
 19 5 of title 5, United States Code, standards for the  
 20 operation of a branch office (as defined in the last  
 21 sentence of section 1861(o) of the Social Security  
 22 Act (42 U.S.C. 1395x(o)), as added by subsection  
 23 (a)).

24 (2) REQUIREMENTS.—In establishing standards  
 25 under paragraph (1), the Secretary shall—

1 (A) provide for the special treatment of  
 2 any home health agency or branch office—

3 (i) that is located in a frontier area;

4 or

5 (ii) with any other special cir-  
 6 cumstance that the Secretary determines is  
 7 appropriate; and

8 (B) allow the use of technology used by the  
 9 home health agency to supervise the branch of-  
 10 fice.

11 (3) CONSULTATION.—The Secretary shall es-  
 12 tablish the regulations under this subsection in con-  
 13 sultation with representatives of the home health in-  
 14 dustry.

15 **SEC. 305. TREATMENT OF HOME HEALTH SERVICES PRO-**  
 16 **VIDED IN CERTAIN COUNTIES.**

17 (a) IN GENERAL.—Notwithstanding any other provi-  
 18 sion of law, effective for home health services provided  
 19 under the prospective payment system under section 1895  
 20 of the Social Security Act (42 U.S.C. 1395fff) during fis-  
 21 cal year 2001 in an applicable county, the geographic ad-  
 22 justment factors applicable in such year to hospitals phys-  
 23 ically located in such county under section 1886(d) of such  
 24 Act (42 U.S.C. 1395ww(d)) (including the factors applica-  
 25 ble to such hospitals by reason of any reclassification or

1 deemed reclassification) shall be deemed to apply to such  
 2 services instead of the area wage adjustment factors that  
 3 would otherwise be applicable to such services under sec-  
 4 tion 1895(b)(4)(C) of such Act (42 U.S.C.  
 5 1395fff(b)(4)(C)).

6 (b) APPLICABLE COUNTY DEFINED.—For purposes  
 7 of subsection (a), the term “applicable county” means any  
 8 of the following counties:

- 9 (1) Dutchess County, New York.
- 10 (2) Orange County, New York.
- 11 (3) Clinton County, New York.
- 12 (4) Ulster County, New York.
- 13 (5) Otsego County, New York.
- 14 (6) Cayuga County, New York.
- 15 (7) St. Jefferson County, New York.

## 16 **Subtitle B—Direct Graduate**

## 17 **Medical Education**

### 18 **SEC. 311. NOT COUNTING CERTAIN GERIATRIC RESIDENTS**

### 19 **AGAINST GRADUATE MEDICAL EDUCATION**

### 20 **LIMITATIONS.**

21 For cost reporting periods beginning on or after Oc-  
 22 tober 1, 2000, and before October 1, 2005, in applying  
 23 the limitations regarding the total number of full-time  
 24 equivalent interns and residents in the field of allopathic  
 25 or osteopathic medicine under subsections (d)(5)(B)(v)

1 and (h)(4)(F) of section 1886 of the Social Security Act  
 2 (42 U.S.C. 1395ww) for a hospital, the Secretary of  
 3 Health and Human Services shall not take into account  
 4 a maximum of 3 interns or residents in the field of geri-  
 5 atric medicine to the extent the hospital increases the  
 6 number of geriatric interns or residents above the number  
 7 of such interns or residents for the hospital's most recent  
 8 cost reporting period ending before October 1, 2000.

9 **SEC. 312. PROGRAM OF PAYMENTS TO CHILDREN'S HOS-**  
 10 **PITALS THAT OPERATE GRADUATE MEDICAL**  
 11 **EDUCATION PROGRAMS.**

12 Part A of title XI (42 U.S.C. 1301 et seq.) is amend-  
 13 ed by adding after section 1150 the following new section:  
 14 “PROGRAM OF PAYMENTS TO CHILDREN’S HOSPITALS  
 15 THAT OPERATE GRADUATE MEDICAL EDUCATION  
 16 PROGRAMS

17 “SEC. 1150A. (a) PAYMENTS.—The Secretary shall  
 18 make 2 payments under this section to each children’s  
 19 hospital for each of fiscal years 2002 through 2005, 1 for  
 20 the direct expenses and the other for the indirect expenses  
 21 associated with operating approved graduate medical resi-  
 22 dency training programs.

23 “(b) AMOUNT OF PAYMENTS.—

24 “(1) IN GENERAL.—Subject to paragraph (2),  
 25 the amounts payable under this section to a chil-  
 26 dren’s hospital for an approved graduate medical

1        residency training program for a fiscal year are each  
2        of the following amounts:

3                “(A) DIRECT EXPENSE AMOUNT.—The  
4                amount determined under subsection (c) for di-  
5                rect expenses associated with operating ap-  
6                proved graduate medical residency training pro-  
7                grams.

8                “(B) INDIRECT EXPENSE AMOUNT.—The  
9                amount determined under subsection (d) for in-  
10              direct expenses associated with the treatment of  
11              more severely ill patients and the additional  
12              costs relating to teaching residents in such pro-  
13              grams.

14              “(2) CAPPED AMOUNT.—

15              “(A) IN GENERAL.—The total of the pay-  
16              ments made to children’s hospitals under sub-  
17              paragraph (A) or (B) of paragraph (1) in a fis-  
18              cal year shall not exceed the funds appropriated  
19              under paragraph (1) or (2), respectively, of sub-  
20              section (f) for such payments for that fiscal  
21              year.

22              “(B) PRO RATA REDUCTIONS OF PAY-  
23              MENTS FOR DIRECT EXPENSES.—If the Sec-  
24              retary determines that the amount of funds ap-  
25              propriated under subsection (f)(1) for a fiscal



1           year is insufficient to provide the total amount  
 2           of payments otherwise due for such periods  
 3           under paragraph (1)(A), the Secretary shall re-  
 4           duce the amounts so payable on a pro rata  
 5           basis to reflect such shortfall.

6           “(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE  
 7 MEDICAL EDUCATION.—

8           “(1) IN GENERAL.—The amount determined  
 9           under this subsection for payments to a children’s  
 10          hospital for direct graduate expenses relating to ap-  
 11          proved graduate medical residency training pro-  
 12          grams for a fiscal year is equal to the product of—

13                  “(A) the updated per resident amount for  
 14          direct graduate medical education, as deter-  
 15          mined under paragraph (2); and

16                  “(B) the average number of full-time  
 17          equivalent residents in the hospital’s graduate  
 18          approved medical residency training programs  
 19          (as determined under section 1886(h)(4)) dur-  
 20          ing the fiscal year.

21           “(2) UPDATED PER RESIDENT AMOUNT FOR DI-  
 22          RECT GRADUATE MEDICAL EDUCATION.—The up-  
 23          dated per resident amount for direct graduate med-  
 24          ical education for a hospital for a fiscal year is an  
 25          amount determined as follows:

1           “(A) DETERMINATION OF HOSPITAL SIN-  
2           GLE PER RESIDENT AMOUNT.—The Secretary  
3           shall compute for each hospital operating an  
4           approved graduate medical education program  
5           (regardless of whether or not it is a children’s  
6           hospital) a single per resident amount equal to  
7           the average (weighted by number of full-time  
8           equivalent residents) of the primary care per  
9           resident amount and the non-primary care per  
10          resident amount computed under section  
11          1886(h)(2) for cost reporting periods ending  
12          during fiscal year 1997.

13          “(B) DETERMINATION OF WAGE AND NON-  
14          WAGE-RELATED PROPORTION OF THE SINGLE  
15          PER RESIDENT AMOUNT.—The Secretary shall  
16          estimate the average proportion of the single  
17          per resident amounts computed under subpara-  
18          graph (A) that is attributable to wages and  
19          wage-related costs.

20          “(C) STANDARDIZING PER RESIDENT  
21          AMOUNTS.—The Secretary shall establish a  
22          standardized per resident amount for each such  
23          hospital—

24                  “(i) by dividing the single per resident  
25                  amount computed under subparagraph (A)

1 into a wage-related portion and a non-  
 2 wage-related portion by applying the pro-  
 3 portion determined under subparagraph  
 4 (B);

5 “(ii) by dividing the wage-related por-  
 6 tion by the factor applied under section  
 7 1886(d)(3)(E) for discharges occurring  
 8 during fiscal year 1999 for the hospital’s  
 9 area; and

10 “(iii) by adding the non-wage-related  
 11 portion to the amount computed under  
 12 clause (ii).

13 “(D) DETERMINATION OF NATIONAL AV-  
 14 ERAGE.—The Secretary shall compute a na-  
 15 tional average per resident amount equal to the  
 16 average of the standardized per resident  
 17 amounts computed under subparagraph (C) for  
 18 such hospitals, with the amount for each hos-  
 19 pital weighted by the average number of full-  
 20 time equivalent residents at such hospital.

21 “(E) APPLICATION TO INDIVIDUAL HOS-  
 22 PITALS.—The Secretary shall compute for each  
 23 such hospital that is a children’s hospital a per  
 24 resident amount—

1 “(i) by dividing the national average  
 2 per resident amount computed under sub-  
 3 paragraph (D) into a wage-related portion  
 4 and a non-wage-related portion by applying  
 5 the proportion determined under subpara-  
 6 graph (B);

7 “(ii) by multiplying the wage-related  
 8 portion by the factor described in subpara-  
 9 graph (C)(ii) for the hospital’s area; and

10 “(iii) by adding the non-wage-related  
 11 portion to the amount computed under  
 12 clause (ii).

13 “(F) UPDATING RATE.—The Secretary  
 14 shall update such per resident amount for each  
 15 such children’s hospital by the estimated per-  
 16 centage increase in the Consumer Price Index  
 17 for all urban consumers (U.S. city average)  
 18 during the period beginning October 1997, and  
 19 ending with the midpoint of the Federal fiscal  
 20 year for which payments are made.

21 “(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL  
 22 EDUCATION.—

23 “(1) IN GENERAL.—The amount determined  
 24 under this subsection for payments to a children’s  
 25 hospital for indirect expenses associated with the

1 treatment of more severely ill patients and the addi-  
 2 tional costs related to the teaching of residents for  
 3 a fiscal year is equal to an amount determined ap-  
 4 propriate by the Secretary.

5 “(2) FACTORS.—In determining the amount  
 6 under paragraph (1), the Secretary shall—

7 “(A) take into account variations in case  
 8 mix and regional wage levels among children’s  
 9 hospitals and the number of full-time equivalent  
 10 residents in the hospitals’ approved graduate  
 11 medical residency training programs; and

12 “(B) assure that the aggregate of the pay-  
 13 ments for indirect expenses associated with the  
 14 treatment of more severely ill patients and the  
 15 additional costs related to the teaching of resi-  
 16 dents under this section in a fiscal year are  
 17 equal to the amount appropriated for such ex-  
 18 penses for the fiscal year involved under sub-  
 19 section (f)(2).

20 “(e) MAKING OF PAYMENTS.—

21 “(1) INTERIM PAYMENTS.—The Secretary shall  
 22 determine, before the beginning of each fiscal year  
 23 involved for which payments may be made for a hos-  
 24 pital under this section, the amounts of the pay-  
 25 ments for direct graduate medical education and in-

1 direct medical education for such fiscal year and  
2 shall (subject to paragraph (2)) make the payments  
3 of such amounts in 26 equal interim installments  
4 during such period. Such interim payments to each  
5 individual hospital shall be based on the number of  
6 residents reported in the hospital's most recently  
7 filed medicare cost report prior to the application  
8 date for the Federal fiscal year for which the interim  
9 payment amounts are established.

10 “(2) WITHHOLDING.—

11 “(A) IN GENERAL.—Subject to subpara-  
12 graph (B), the Secretary shall withhold 25 per-  
13 cent from each interim installment for direct  
14 and indirect graduate medical education paid  
15 under paragraph (1).

16 “(B) REDUCTION OF WITHHOLDING.—The  
17 Secretary shall reduce the percent withheld  
18 from each installment pursuant to subpara-  
19 graph (A) if the Secretary determines that such  
20 reduced percent will provide the Secretary with  
21 a reasonable level of assurance that most hos-  
22 pitals will not be overpaid on an interim basis.

23 “(3) RECONCILIATION.—Prior to the end of  
24 each fiscal year, the Secretary shall determine any  
25 changes to the number of residents reported by a

1 hospital and shall use that number of residents to  
 2 determine the final amount payable to the hospital  
 3 for the current fiscal year for both direct expense  
 4 and indirect expense amounts. Based on such deter-  
 5 mination, the Secretary shall recoup any overpay-  
 6 ments made or pay any balance due to the extent  
 7 possible. In the event that a hospital's interim pay-  
 8 ments were greater than the final amount to which  
 9 it is entitled, the Secretary shall have the option of  
 10 recouping that excess amount in determining the  
 11 amount to be paid in the subsequent year to that  
 12 hospital. The final amount so determined shall be  
 13 considered a final intermediary determination for  
 14 purposes of applying section 1878 and shall be sub-  
 15 ject to review under that section in the same manner  
 16 as the amount of payment under section 1886(d) is  
 17 subject to review under such section.

18 “(f) AUTHORIZATION OF APPROPRIATIONS.—

19 “(1) DIRECT GRADUATE MEDICAL EDU-  
 20 CATION.—

21 “(A) IN GENERAL.—There are appro-  
 22 priated, out of any money in the Treasury not  
 23 otherwise appropriated, for payments under  
 24 subsection (b)(1)(A) for each of fiscal years  
 25 2002 through 2005, \$95,000,000.

1           “(B) CARRYOVER OF EXCESS.—The  
 2           amounts appropriated under subparagraph (A)  
 3           for each fiscal year shall remain available for  
 4           obligation through the end of the subsequent  
 5           fiscal year.

6           “(2) INDIRECT MEDICAL EDUCATION.—There  
 7           are appropriated, out of any money in the Treasury  
 8           not otherwise appropriated, for payments under sub-  
 9           section (b)(1)(A) for each of fiscal years 2002  
 10          through 2005, \$190,000,000.

11          “(g) DEFINITIONS.—In this section:

12           “(1) APPROVED GRADUATE MEDICAL RESI-  
 13          DENCY TRAINING PROGRAM.—The term ‘approved  
 14          graduate medical residency training program’ has  
 15          the meaning given the term ‘approved medical resi-  
 16          dency training program’ in section 1886(h)(5)(A).

17           “(2) CHILDREN’S HOSPITAL.—The term ‘chil-  
 18          dren’s hospital’ means a hospital with a medicare  
 19          payment agreement and which is excluded from the  
 20          medicare inpatient prospective payment system pur-  
 21          suant to section 1886(d)(1)(B)(iii) and its accom-  
 22          panying regulations.

23           “(3) DIRECT GRADUATE MEDICAL EDUCATION  
 24          COSTS.—The term ‘direct graduate medical edu-



1 cation costs' has the meaning given such term in  
 2 section 1886(h)(5)(C).”.

3 **SEC. 313. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**  
 4 **CLINICAL PSYCHOLOGISTS IN PAYMENTS TO**  
 5 **HOSPITALS.**

6 Effective for cost reporting periods beginning on or  
 7 after October 1, 1999, for purposes of payments to hos-  
 8 pitals under the medicare program under title XVIII of  
 9 the Social Security Act (42 U.S.C. 1395 et seq.) for costs  
 10 of approved educational activities (as defined in section  
 11 413.85 of title 42 of the Code of Federal Regulations),  
 12 such approved educational activities shall include the clin-  
 13 ical portion of professional educational training programs,  
 14 recognized by the Secretary, for clinical psychologists.

15 **SEC. 314. TREATMENT OF CERTAIN NEWLY ESTABLISHED**  
 16 **RESIDENCY PROGRAMS IN COMPUTING**  
 17 **MEDICARE PAYMENTS FOR THE COSTS OF**  
 18 **MEDICAL EDUCATION.**

19 (a) IN GENERAL.—Section 1886(h)(4)(H) (42  
 20 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the  
 21 end the following new clause:

22 “(v) TREATMENT OF CERTAIN NEWLY  
 23 ESTABLISHED PROGRAMS.—Any hospital  
 24 that has received payments under this sub-  
 25 section for a cost reporting period ending

1 before January 1, 1995, and that operates  
 2 an approved medical residency training  
 3 program established on or after August 5,  
 4 1997, shall be treated as meeting the re-  
 5 quirements for an adjustment under the  
 6 rules prescribed pursuant to clause (i) with  
 7 respect to such program if—

8 “(I) such program received ac-  
 9 creditation from the American Council  
 10 of Graduate Medical Education not  
 11 later than August 5, 1998;

12 “(II) such program was in oper-  
 13 ation (with 1 or more residents in  
 14 training) as of January 1, 2000;

15 “(III) such hospital is located in  
 16 an area that is contiguous to a rural  
 17 area and serves individuals from such  
 18 rural area; and

19 “(IV) such hospital serves a med-  
 20 ical service area with a population  
 21 that is less than 500,000.”.

22 (b) EFFECTIVE DATE.—The amendment made by  
 23 subsection (a) shall take effect as if included in the enact-  
 24 ment of section 4623 of BBA (111 Stat. 477).

## **Subtitle C—Miscellaneous Provisions**

### **SEC. 321. WAIVER OF 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE OF INDIVIDUALS DIS- ABLED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS).**

(a) IN GENERAL.—Section 226 (42 U.S.C. 426) is amended—

(1) by redesignating subsection (h) as subsection (j) and by moving such subsection to the end of the section; and

(2) by inserting after subsection (g) the following new subsection:

“(h) For purposes of applying this section in the case of an individual medically determined to have amyotrophic lateral sclerosis (ALS), the following special rules apply:

“(1) Subsection (b) shall be applied as if there were no requirement for any entitlement to benefits, or status, for a period longer than 1 month.

“(2) The entitlement under such subsection shall begin with the first month (rather than twenty-fifth month) of entitlement or status.

“(3) Subsection (f) shall not be applied.”.

1 (b) CONFORMING AMENDMENT.—Section 1837 (42  
2 U.S.C. 1395p) is amended by adding at the end the fol-  
3 lowing new subsection:

4 “(j) In applying this section in the case of an indi-  
5 vidual who is entitled to benefits under part A pursuant  
6 to the operation of section 226(h), the following special  
7 rules apply:

8 “(1) The initial enrollment period under sub-  
9 section (d) shall begin on the first day of the first  
10 month in which the individual satisfies the require-  
11 ment of section 1836(1).

12 “(2) In applying subsection (g)(1), the initial  
13 enrollment period shall begin on the first day of the  
14 first month of entitlement to disability insurance  
15 benefits referred to in such subsection.”.

16 (c) EFFECTIVE DATE.—The amendments made by  
17 this section shall apply to benefits for months beginning  
18 after the date of enactment of this Act.

**TITLE IV—RURAL PROVIDER  
PROVISIONS  
Subtitle A—Critical Access  
Hospitals**

**SEC. 401. PAYMENTS TO CRITICAL ACCESS HOSPITALS FOR  
CLINICAL DIAGNOSTIC LABORATORY TESTS.**

(a) PAYMENT ON COST BASIS WITHOUT BENE-  
FICIARY COST-SHARING.—

(1) IN GENERAL.—Section 1833(a)(6) (42  
U.S.C. 1395l(a)(6)) is amended by inserting “(in-  
cluding clinical diagnostic laboratory services fur-  
nished by a critical access hospital)” after “out-  
patient critical access hospital services”.

(2) NO BENEFICIARY COST-SHARING.—

(A) IN GENERAL.—Section 1834(g) (42  
U.S.C. 1395m(g)) is amended by inserting  
“(except that in the case of clinical diagnostic  
laboratory services furnished by a critical access  
hospital the amount of payment shall be equal  
to 100 percent of the reasonable costs of the  
critical access hospital in providing such serv-  
ices)” before the period at the end.

(B) BBRA AMENDMENT.—Section 1834(g)  
(42 U.S.C. 1395m(g)), as amended by section

1           403(d) of BBRA (113 Stat. 1501A–371), is  
2           amended—

3                   (i) in paragraph (1), by inserting  
4                   “(except that in the case of clinical diag-  
5                   nostic laboratory services furnished by a  
6                   critical access hospital the amount of pay-  
7                   ment shall be equal to 100 percent of the  
8                   reasonable costs of the critical access hos-  
9                   pital in providing such services)” after  
10                  “such services”; and

11                   (ii) in paragraph (2)(A), by inserting  
12                   “(except that in the case of clinical diag-  
13                   nostic laboratory services furnished by a  
14                   critical access hospital the amount of pay-  
15                   ment shall be equal to 100 percent of the  
16                   reasonable costs of the critical access hos-  
17                   pital in providing such services)” before  
18                  the period at the end.

19           (b)   CONFORMING    AMENDMENTS.—Paragraphs  
20   (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C.  
21   1395l(a)(1)(D)(i); 1395l(a)(2)(D)(i)) are each amended  
22   by striking “or which are furnished on an outpatient basis  
23   by a critical access hospital”.

1 (c) TECHNICAL AMENDMENT.—Section 403(d)(2) of  
2 BBRA (113 Stat. 1501A–371) is amended by striking  
3 “subsection (a)” and inserting “paragraph (1)”.

4 (d) EFFECTIVE DATES.—

5 (1) IN GENERAL.—Except as provided in para-  
6 graph (2), the amendments made by this section  
7 shall apply to services furnished on or after Novem-  
8 ber 29, 1999.

9 (2) BBRA AND TECHNICAL AMENDMENTS.—  
10 The amendments made by subsections (a)(2)(B) and  
11 (c) shall take effect as if included in the enactment  
12 of section 403(d) of BBRA (113 Stat. 1501A–371).

13 **SEC. 402. REVISION OF PAYMENT FOR PROFESSIONAL**  
14 **SERVICES PROVIDED BY A CRITICAL ACCESS**  
15 **HOSPITAL.**

16 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.  
17 1395m(g)(2)(B)), as amended by section 403(d) of BBRA  
18 (113 Stat. 1501A–371), is amended by inserting “120  
19 percent of” after “hospital services,”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 subsection (a) shall take effect as if included in the enact-  
22 ment of section 403(d) of BBRA (113 Stat. 1501A–371).

1 **SEC. 403. PERMITTING CRITICAL ACCESS HOSPITALS TO**  
2 **OPERATE PPS EXEMPT DISTINCT PART PSY-**  
3 **CHIATRIC AND REHABILITATION UNITS.**

4 (a) CRITERIA FOR DESIGNATION AS A CRITICAL AC-  
5 CESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C.  
6 1395i–4(c)(2)(B)(iii)) is amended by inserting “excluding  
7 any psychiatric or rehabilitation unit of the facility which  
8 is a distinct part of the facility,” before “provides not”.

9 (b) DEFINITION OF PPS EXEMPT DISTINCT PART  
10 PSYCHIATRIC AND REHABILITATION UNITS.—Section  
11 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended  
12 by inserting before the last sentence the following new sen-  
13 tence: “In establishing such definition, the Secretary may  
14 not exclude from such definition a psychiatric or rehabili-  
15 tation unit of a critical access hospital which is a distinct  
16 part of such hospital solely because such hospital is ex-  
17 empt from the prospective payment system under this sec-  
18 tion.”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall take effect on the date of enactment of  
21 this Act.



1     **Subtitle B—Medicare Dependent,**  
 2     **Small Rural Hospital Program**

3     **SEC. 411. MAKING THE MEDICARE DEPENDENT, SMALL**  
 4     **RURAL HOSPITAL PROGRAM PERMANENT.**

5         (a)           PAYMENT           METHODOLOGY.—Section  
 6     1886(d)(5)(G)   (42    U.S.C.    1395ww(d)(5)(G))   is  
 7     amended—

8                 (1) in clause (i), by striking “and before Octo-  
 9     ber 1, 2006,”; and

10                (2) in clause (ii)(II), by striking “and before  
 11     October 1, 2006,”.

12         (b) CONFORMING AMENDMENTS.—

13                (1) TARGET AMOUNT.—Section 1886(b)(3)(D)  
 14     (42 U.S.C. 1395ww(b)(3)(D)) is amended—

15                         (A) in the matter preceding clause (i), by  
 16     striking “and before October 1, 2006,”; and

17                         (B) in clause (iv), by striking “through fis-  
 18     cal year 2005,” and inserting “or any subse-  
 19     quent fiscal year,”.

20                (2) PERMITTING HOSPITALS TO DECLINE RE-  
 21     CLASSIFICATION.—Section 13501(e)(2) of the Omni-  
 22     bus Budget Reconciliation Act of 1993 (42 U.S.C.  
 23     1395ww note), as amended by section 404(b)(2) of  
 24     BBRA (113 Stat. 1501A–372), is amended by strik-  
 25     ing “or fiscal year 2000 through fiscal year 2005”

1 and inserting “fiscal year 2000, or any subsequent  
2 fiscal year,”.

3 **SEC. 412. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**  
4 **PENDENT, SMALL RURAL HOSPITAL PRO-**  
5 **GRAM ON DISCHARGES DURING ANY OF THE**  
6 **3 MOST RECENT AUDITED COST REPORTING**  
7 **PERIODS.**

8 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)  
9 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-  
10 serting “, or any of the 3 most recent audited cost report-  
11 ing periods,” after “1987”.

12 (b) EFFECTIVE DATE.—The amendment made by  
13 this section shall apply with respect to cost reporting peri-  
14 ods beginning on or after the date of enactment of this  
15 Act.

16 **Subtitle C—Sole Community**  
17 **Hospitals**

18 **SEC. 421. EXTENSION OF OPTION TO USE REBASED TARGET**  
19 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**  
20 **PITALS.**

21 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42  
22 U.S.C. 1395ww(b)(3)(I)(i)) is amended—

23 (1) in the matter preceding subclause (I)—

24 (A) by striking “that for its cost reporting  
25 period beginning during 1999 is paid on the

1 basis of the target amount applicable to the  
 2 hospital under subparagraph (C) and that  
 3 elects (in a form and manner determined by the  
 4 Secretary) this subparagraph to apply to the  
 5 hospital”; and

6 (B) by striking “substituted for such tar-  
 7 get amount” and inserting “substituted, if such  
 8 substitution results in a greater payment under  
 9 this section for such hospital, for the amount  
 10 otherwise determined under subsection  
 11 (d)(5)(D)(i)”;

12 (2) in subclause (I), by striking “target amount  
 13 otherwise applicable” and all that follows through  
 14 “target amount’”)” and inserting “the amount other-  
 15 wise applicable to the hospital under subsection  
 16 (d)(5)(D)(i) (referred to in this clause as the ‘sub-  
 17 section (d)(5)(D)(i) amount’)”;

18 (3) in each of subclauses (II) and (III), by  
 19 striking “subparagraph (C) target amount” and in-  
 20 serting “subsection (d)(5)(D)(i) amount”.

21 (b) EFFECTIVE DATE.—The amendments made by  
 22 this section shall take effect as if included in the enact-  
 23 ment of section 405 of BBRA (113 Stat. 1501A–372).

1 **SEC. 422. DEEMING A CERTAIN HOSPITAL AS A SOLE COM-**  
 2 **MUNITY HOSPITAL.**

3 Notwithstanding any other provision of law, for pur-  
 4 poses of discharges occurring on or after October 1, 2000,  
 5 the Greensville Memorial Hospital located in Emporia,  
 6 Virginia shall be deemed to have satisfied the travel and  
 7 time criteria under section 1886(d)(5)(D)(iii)(II) of the  
 8 Social Security Act (42 U.S.C. 1395ww(d)(5)(D)(iii)(II))  
 9 for classification as a sole community hospital.

10 **Subtitle D—Other Rural Hospital**  
 11 **Provisions**

12 **SEC. 431. EXEMPTION OF HOSPITAL SWING-BED PROGRAM**  
 13 **FROM THE PPS FOR SKILLED NURSING FA-**  
 14 **CILITIES.**

15 (a) EXEMPTION FOR MEDICARE SWING-BED HOS-  
 16 PITALS.—

17 (1) IN GENERAL.—Section 1888(e)(7) (42  
 18 U.S.C. 1395yy(e)(7)(A)) is amended—

19 (A) in the heading, by striking “TRANSI-  
 20 TION” and inserting “EXEMPTION”;

21 (B) by striking subparagraph (A) and in-  
 22 serting the following new subparagraph:

23 “(A) IN GENERAL.—The prospective pay-  
 24 ment system under this subsection shall not  
 25 apply to items and services provided by a facil-  
 26 ity described in subparagraph (B).”; and

1 (C) in subparagraph (B), by striking “, for  
2 which payment” and all that follows before the  
3 period.

4 (2) EFFECTIVE DATE.—The amendments made  
5 by paragraph (1) shall take effect as if included in  
6 the enactment of section 4432 of BBA (111 Stat.  
7 414).

8 (b) CHANGE IN EFFECTIVE DATE OF BBRA AMEND-  
9 MENTS.—

10 (1) IN GENERAL.—Section 408(c) of BBRA  
11 (113 Stat. 1501A–375) is amended by striking “the  
12 date that is” and all that follows and inserting  
13 “January 1, 2001.”.

14 (2) EFFECTIVE DATE.—The amendment made  
15 by paragraph (1) shall take effect as if included in  
16 the enactment of section 408 of BBRA (113 Stat.  
17 1501A–375).

18 **SEC. 432. PERMANENT GUARANTEE OF PRE-BBA PAYMENT**  
19 **LEVELS FOR OUTPATIENT SERVICES FUR-**  
20 **NISHED BY RURAL HOSPITALS.**

21 (a) IN GENERAL.—Section 1833(t)(7)(D), as amend-  
22 ed by section 203, is amended to read as follows:

23 “(D) HOLD HARMLESS PROVISIONS FOR  
24 SMALL RURAL AND CANCER HOSPITALS.—In  
25 the case of a hospital located in a rural area

1 and that has not more than 100 beds or a hos-  
 2 pital described in section 1886(d)(1)(B)(v), for  
 3 covered OPD services for which the PPS  
 4 amount is less than the pre-BBA amount, the  
 5 amount of payment under this subsection shall  
 6 be increased by the amount of such dif-  
 7 ference.”.

8 (b) EFFECTIVE DATE.—The amendment made by  
 9 subsection (a) shall take effect as if included in the enact-  
 10 ment of section 202 of BBRA (111 Stat. 1501A–342).

11 **SEC. 433. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**  
 12 **SERVICES.**

13 (a) IN GENERAL.—Section 1848(i) (42 U.S.C.  
 14 1395w–4(i)) is amended by adding at the end the fol-  
 15 lowing new paragraph:

16 “(4) TREATMENT OF CERTAIN PHYSICIAN PA-  
 17 THOLOGY SERVICES.—

18 “(A) IN GENERAL.—Notwithstanding any  
 19 other provision of law, when an independent  
 20 laboratory furnishes the technical component of  
 21 a physician pathology service with respect to a  
 22 fee-for-service medicare beneficiary who is a pa-  
 23 tient of a grandfathered hospital, such compo-  
 24 nent shall be treated as a service for which pay-

1           ment shall be made to the laboratory under this  
2           section and not as—

3                   “(i) an inpatient hospital service for  
4                   which payment is made to the hospital  
5                   under section 1886(d); or

6                   “(ii) a hospital outpatient service for  
7                   which payment is made to the hospital  
8                   under the prospective payment system  
9                   under section 1834(t).

10           “(B) DEFINITIONS.—In this paragraph:

11                   “(i) GRANDFATHERED HOSPITAL.—  
12                   The term ‘grandfathered hospital’ means a  
13                   hospital that had an arrangement with an  
14                   independent laboratory—

15                           “(I) that was in effect as of July  
16                           22, 1999; and

17                           “(II) under which the laboratory  
18                           furnished the technical component of  
19                           physician pathology services with re-  
20                           spect to patients of the hospital and  
21                           submitted a claim for payment for  
22                           such component to a carrier with a  
23                           contract under section 1842 (and not  
24                           to the hospital).

1                   “(ii) FEE-FOR-SERVICE MEDICARE  
 2 BENEFICIARY.—The term ‘fee-for-service  
 3 medicare beneficiary’ means an individual  
 4 who is not enrolled—

5                   “(I) in a Medicare+Choice plan  
 6 under part C;

7                   “(II) in a plan offered by an eli-  
 8 gible organization under section 1876;

9                   “(III) with a PACE provider  
 10 under section 1894;

11                   “(IV) in a medicare managed  
 12 care demonstration project; or

13                   “(V) in the case of a service fur-  
 14 nished to an individual on an out-  
 15 patient basis, in a health care prepay-  
 16 ment plan under section  
 17 1833(a)(1)(A).”.

18           (b) EFFECTIVE DATE.—The amendment made by  
 19 this section shall apply to services furnished on or after  
 20 January 1, 2001.



## 1   **Subtitle E—Other Rural Provisions**

### 2   **SEC. 441. REVISION OF BONUS PAYMENTS FOR SERVICES** 3                   **FURNISHED IN HEALTH PROFESSIONAL** 4                   **SHORTAGE AREAS.**

5           (a) EXPANSION OF BONUS PAYMENTS TO INCLUDE  
 6 PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERV-  
 7 ICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is  
 8 amended—

9           (1) by inserting “(or services furnished by a  
 10 physician assistant or nurse practitioner that would  
 11 be physicians’ services if furnished by a physician)”  
 12 after “physicians’ services”;

13           (2) by inserting “, physician assistant (in the  
 14 case of a physician assistant described in subpara-  
 15 graph (C)(ii) of section 1842(b)(6)), or nurse practi-  
 16 tioner” after “physician”; and

17           (3) by striking “clause (A) of section  
 18 1842(b)(6)” and inserting “subparagraphs (A) and  
 19 (C)(i) of such section”.

20           (b) ELIMINATION OF REQUIREMENT TO MAKE  
 21 BONUS PAYMENTS ON MONTHLY OR QUARTERLY  
 22 BASIS.—Section 1833(m) (42 U.S.C. 1395l(m)) is amend-  
 23 ed by striking “(on a monthly or quarterly basis)”.

24           (c) EFFECTIVE DATES.—

1           (1) IN GENERAL.—The amendments made by  
 2           subsection (a) shall apply to services furnished on or  
 3           after July 1, 2001.

4           (2) MONTHLY OR QUARTERLY PAYMENTS.—The  
 5           amendment made by subsection (b) shall apply to  
 6           services furnished on or after the first day of the  
 7           first calendar quarter beginning at least 240 days  
 8           after the date of enactment of this Act.

9   **SEC. 442. PROVIDER-BASED RURAL HEALTH CLINIC CAP**  
 10           **EXEMPTION.**

11           (a) IN GENERAL.—The matter in section 1833(f) (42  
 12   U.S.C. 1395l(f)) preceding paragraph (1) is amended by  
 13   striking “with less than 50 beds” and inserting “with an  
 14   average daily patient census that does not exceed 50”.

15           (b) EFFECTIVE DATE.—The amendment made by  
 16   subparagraph (A) shall apply to services furnished on or  
 17   after January 1, 2001.

18   **SEC. 443. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**  
 19           **SERVICES.**

20           (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT  
 21   SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.  
 22   1395u(b)(6)(C)) is amended by striking “for such services  
 23   provided before January 1, 2003,”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall take effect on the date of enactment  
 3 of this Act.

4 **SEC. 444. BONUS PAYMENTS FOR RURAL HOME HEALTH**  
 5 **AGENCIES IN 2001 AND 2002.**

6 (a) INCREASE IN PAYMENT RATES FOR RURAL  
 7 AGENCIES IN 2001 AND 2002.—Section 1895(b) (42  
 8 U.S.C. 1395fff(b)) is amended by adding at the end the  
 9 following new paragraph:

10 “(7) ADDITIONAL PAYMENT AMOUNT FOR  
 11 SERVICES FURNISHED IN RURAL AREAS IN 2001 AND  
 12 2002.—In the case of home health services furnished  
 13 in a rural area (as defined in section 1886(d)(2)(D))  
 14 during 2001 or 2002, the Secretary shall provide for  
 15 an addition or adjustment to the payment amount  
 16 otherwise made under this section for services fur-  
 17 nished in a rural area in an amount equal to 10 per-  
 18 cent of the amount otherwise determined under this  
 19 subsection.”.

20 (b) WAIVING BUDGET NEUTRALITY.—Section  
 21 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by add-  
 22 ing at the end the following new subparagraph:

23 “(D) NO ADJUSTMENT FOR ADDITIONAL  
 24 PAYMENTS FOR RURAL SERVICES.—The Sec-  
 25 retary shall not reduce the standard prospective

1 payment amount (or amounts) under this para-  
 2 graph applicable to home health services fur-  
 3 nished during a period to offset the increase in  
 4 payments resulting from the application of  
 5 paragraph (7) (relating to services furnished in  
 6 rural areas).”.

7 **SEC. 445. EXCLUSION OF CLINICAL SOCIAL WORKER SERV-**  
 8 **ICES AND SERVICES PERFORMED UNDER A**  
 9 **CONTRACT WITH A RURAL HEALTH CLINIC**  
 10 **OR FEDERALLY QUALIFIED HEALTH CENTER**  
 11 **FROM THE PPS FOR SNFs.**

12 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42  
 13 U.S.C. 1395yy(e)(2)(A)(ii)) is amended—

14 (1) in the first sentence, by inserting “clinical  
 15 social worker services,” after “qualified psychologist  
 16 services,”; and

17 (2) by inserting after the first sentence the fol-  
 18 lowing: “Services described in this clause also in-  
 19 clude services that are provided by a physician, a  
 20 physician assistant, a nurse practitioner, a certified  
 21 nurse midwife, a qualified psychologist, or a clinical  
 22 social worker who is employed, or otherwise under  
 23 contract, with a rural health clinic or a Federally  
 24 qualified health center.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 this section shall apply to services provided on or after  
 3 the date which is 60 days after the date of enactment of  
 4 this Act.

5 **SEC. 446. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
 6 **PIST SERVICES PROVIDED IN RURAL HEALTH**  
 7 **CLINICS.**

8 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-  
 9 PIST SERVICES.—

10 (1) PROVISION OF SERVICES IN RURAL HEALTH  
 11 CLINICS.—Section 1861(aa)(1)(B) (42 U.S.C.  
 12 1395x(aa)(1)(B)) is amended by striking “Sec-  
 13 retary)” and inserting “Secretary), by a marriage  
 14 and family therapist (as defined in subsection  
 15 (xx)(2)),”.

16 (2) MARRIAGE AND FAMILY THERAPIST SERV-  
 17 ICES DEFINED.—Section 1861 (42 U.S.C. 1395x),  
 18 as amended by section 234(b), is amended by adding  
 19 at the end the following new subsection:

20 “Marriage and Family Therapist Services  
 21 “(xx)(1) The term ‘marriage and family therapist  
 22 services’ means services performed by a marriage and  
 23 family therapist (as defined in paragraph (2)) for the diag-  
 24 nosis and treatment of mental illnesses, which the mar-  
 25 riage and family therapist is legally authorized to perform

1 under State law (or the State regulatory mechanism pro-  
2 vided by State law) of the State in which such services  
3 are performed, as would otherwise be covered if furnished  
4 by a physician or as an incident to a physician's profes-  
5 sional service, but only if no facility or other provider  
6 charges or is paid any amounts with respect to the fur-  
7 nishing of such services.

8       “(2) The term ‘marriage and family therapist’ means  
9 an individual who—

10           “(A) possesses a master’s or doctoral degree  
11 which qualifies for licensure or certification as a  
12 marriage and family therapist pursuant to State  
13 law;

14           “(B) after obtaining such degree has performed  
15 at least 2 years of clinical supervised experience in  
16 marriage and family therapy; and

17           “(C)(i) is licensed or certified as a marriage  
18 and family therapist in the State in which marriage  
19 and family therapist services are performed; or

20           “(ii) in the case of a State that does not pro-  
21 vide for such licensure or certification, meets such  
22 other criteria as the Secretary establishes.”.

23       (b) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply with respect to services furnished  
25 on or after January 1, 2002.

1 **SEC. 447. CAPITAL INFRASTRUCTURE REVOLVING LOAN**  
 2 **PROGRAM.**

3 (a) IN GENERAL.—Part A of title XVI of the Public  
 4 Health Service Act (42 U.S.C. 300q et seq.) is amended  
 5 by adding at the end the following new section:

6 “CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

7 “SEC. 1603. (a) AUTHORITY TO MAKE AND GUAR-  
 8 ANTEE LOANS.—

9 “(1) AUTHORITY TO MAKE LOANS.—The Sec-  
 10 retary may make loans from the fund established  
 11 under section 1602(d) to any rural entity for  
 12 projects for capital improvements, including—

13 “(A) the acquisition of land necessary for  
 14 the capital improvements;

15 “(B) the renovation or modernization of  
 16 any building;

17 “(C) the acquisition or repair of fixed or  
 18 major movable equipment; and

19 “(D) such other project expenses as the  
 20 Secretary determines appropriate.

21 “(2) AUTHORITY TO GUARANTEE LOANS.—

22 “(A) IN GENERAL.—The Secretary may  
 23 guarantee the payment of principal and interest  
 24 for loans to rural entities for projects for cap-  
 25 ital improvements described in paragraph (1) to  
 26 non-Federal lenders.

1           “(B) INTEREST SUBSIDIES.—In the case  
2           of a guarantee of any loan to a rural entity  
3           under subparagraph (A)(i), the Secretary may  
4           pay to the holder of such loan and for and on  
5           behalf of the project for which the loan was  
6           made, amounts sufficient to reduce by not more  
7           than 3 percentage points of the net effective in-  
8           terest rate otherwise payable on such loan.

9           “(b) AMOUNT OF LOAN.—The principal amount of  
10          a loan directly made or guaranteed under subsection (a)  
11          for a project for capital improvement may not exceed  
12          \$5,000,000.

13          “(c) FUNDING LIMITATIONS.—

14               “(1) GOVERNMENT CREDIT SUBSIDY EXPO-  
15          SURE.—The total of the Government credit subsidy  
16          exposure under the Credit Reform Act of 1990 scor-  
17          ing protocol with respect to the loans outstanding at  
18          any time with respect to which guarantees have been  
19          issued, or which have been directly made, under sub-  
20          section (a) may not exceed \$50,000,000 per year.

21               “(2) TOTAL AMOUNTS.—Subject to paragraph  
22          (1), the total of the principal amount of all loans di-  
23          rectly made or guaranteed under subsection (a) may  
24          not exceed \$250,000,000 per year.

25          “(d) ADDITIONAL ASSISTANCE.—



1           “(1) NONREPAYABLE GRANTS.—Subject to  
 2           paragraph (2), the Secretary may make a grant to  
 3           a rural entity, in an amount not to exceed \$50,000,  
 4           for purposes of capital assessment and business  
 5           planning.

6           “(2) LIMITATION.—The cumulative total of  
 7           grants awarded under this subsection may not ex-  
 8           ceed \$2,500,000 per year.

9           “(e) TERMINATION OF AUTHORITY.—The Secretary  
 10          may not directly make or guarantee any loan under sub-  
 11          section (a) or make a grant under subsection (d) after  
 12          September 30, 2005.”.

13          (b) RURAL ENTITY DEFINED.—Section 1624 of the  
 14          Public Health Service Act (42 U.S.C. 300s–3) is amended  
 15          by adding at the end the following new paragraph:

16               “(15)(A) The term ‘rural entity’ includes—

17                       “(i) a rural health clinic, as defined in sec-  
 18                       tion 1861(aa)(2) of the Social Security Act;

19                       “(ii) any medical facility with at least 1,  
 20                       but less than 50, beds that is located in—

21                               “(I) a county that is not part of a  
 22                               metropolitan statistical area; or

23                               “(II) a rural census tract of a metro-  
 24                               politan statistical area (as determined  
 25                               under the most recent modification of the

1 Goldsmith Modification, originally pub-  
 2 lished in the Federal Register on February  
 3 27, 1992 (57 Fed. Reg. 6725));

4 “(iii) a hospital that is classified as a  
 5 rural, regional, or national referral center under  
 6 section 1886(d)(5)(C) of the Social Security  
 7 Act; and

8 “(iv) a hospital that is a sole community  
 9 hospital (as defined in section  
 10 1886(d)(5)(D)(iii) of the Social Security Act).

11 “(B) For purposes of subparagraph (A), the  
 12 fact that a clinic, facility, or hospital has been geo-  
 13 graphically reclassified under the medicare program  
 14 under title XVIII of the Social Security Act shall not  
 15 preclude a hospital from being considered a rural en-  
 16 tity under clause (i) or (ii) of subparagraph (A).”.

17 (c) CONFORMING AMENDMENTS.—Section 1602 of  
 18 the Public Health Service Act (42 U.S.C. 300q–2) is  
 19 amended—

20 (1) in subsection (b)(2)(D), by inserting “or  
 21 1603(a)(2)(B)” after “1601(a)(2)(B)”; and

22 (2) in subsection (d)—

23 (A) in paragraph (1)(C), by striking “sec-  
 24 tion 1601(a)(2)(B)” and inserting “sections  
 25 1601(a)(2)(B) and 1603(a)(2)(B)”; and

1 (B) in paragraph (2)(A), by inserting “or  
 2 1603(a)(2)(B)” after “1601(a)(2)(B)”.

3 **SEC. 448. GRANTS FOR UPGRADING DATA SYSTEMS.**

4 (a) IN GENERAL.—Part B of title XVI of the Public  
 5 Health Service Act (42 U.S.C. 300r et seq.) is amended  
 6 by adding at the end the following new section:

7 “GRANTS FOR UPGRADING DATA SYSTEMS

8 “SEC. 1611. (a) GRANTS TO HOSPITALS.—

9 “(1) IN GENERAL.—The Secretary shall estab-  
 10 lish a program to make grants to hospitals that have  
 11 submitted applications in accordance with subsection  
 12 (c) to assist eligible small rural hospitals in offset-  
 13 ting the costs of establishing data systems—

14 “(A) required to—

15 “(i) implement prospective payment  
 16 systems under title XVIII of the Social Se-  
 17 curity Act; and

18 “(ii) comply with the administrative  
 19 simplification requirements under part C  
 20 of title XI of such Act; or

21 “(B) to reduce medication errors.

22 “(2) COSTS.—For purposes of paragraph (1),  
 23 the term ‘costs’ shall include costs associated with—

24 “(A) purchasing computer software and  
 25 hardware; and

1                   “(B) providing education and training to  
2                   hospital staff on computer information systems.

3                   “(3) LIMITATION.—A hospital that has received  
4                   a grant under section 142 of the Medicare, Med-  
5                   icaid, and SCHIP Balanced Budget Refinement Act  
6                   of 2000 is not eligible to receive a grant under this  
7                   section.

8                   “(b) ELIGIBLE SMALL RURAL HOSPITAL DE-  
9                   FINED.—For purposes of this section, the term ‘eligible  
10                  small rural hospital’ means a non-Federal, short-term gen-  
11                  eral acute care hospital that—

12                   “(1) is located in a rural area, as defined for  
13                   purposes of section 1886(d) of the Social Security  
14                   Act; and

15                   “(2) has less than 50 beds.

16                   “(c) APPLICATION.—A hospital seeking a grant  
17                   under this section shall submit an application to the Sec-  
18                   retary at such time and in such form and manner as the  
19                   Secretary specifies.

20                   “(d) AMOUNT OF GRANT.—A grant to a hospital  
21                   under this section may not exceed \$100,000.

22                   “(e) REPORTS.—

23                   “(1) INFORMATION.—A hospital receiving a  
24                   grant under this section shall furnish the Secretary

1 with such information as the Secretary may require  
2 to—

3 “(A) evaluate the project for which the  
4 grant is made; and

5 “(B) ensure that the grant is expended for  
6 the purposes for which it is made.

7 “(2) TIMING OF SUBMISSION.—

8 “(A) INTERIM REPORTS.—The Secretary  
9 shall report to the Committee on Commerce of  
10 the House of Representatives and the Com-  
11 mittee on Health, Education, Labor, and Pen-  
12 sions of the Senate at least annually on the  
13 grant program established under this section,  
14 including in such report information on the  
15 number of grants made, the nature of the  
16 projects involved, the geographic distribution of  
17 grant recipients, and such other matters as the  
18 Secretary deems appropriate.

19 “(B) FINAL REPORT.—The Secretary shall  
20 submit a final report to such committees not  
21 later than 180 days after the completion of all  
22 of the projects for which a grant is made under  
23 this section.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
 2 are authorized to be appropriated such sums as may be  
 3 necessary for grants under this section.”.

4 (b) CONFORMING AMENDMENT.—Section 1820(g)(3)  
 5 (42 U.S.C. 1395i–4(g)(3)) is repealed.

6 **SEC. 449. RELIEF FOR FINANCIALLY DISTRESSED RURAL**  
 7 **HOSPITALS.**

8 Title III of the Public Health Service Act (42 U.S.C.  
 9 241 et seq.) is amended by inserting after section 330D  
 10 the following new section:

11 **“SEC. 330E. RELIEF FOR FINANCIALLY DISTRESSED RURAL**  
 12 **HOSPITALS.**

13 “(a) GRANTS TO SMALL RURAL HOSPITALS.—The  
 14 Secretary, acting through the Health Resources and Serv-  
 15 ices Administration, may award grants to eligible small  
 16 rural hospitals that have submitted applications in accord-  
 17 ance with subsection (c) to provide relief for financial dis-  
 18 tress that has a negative impact on access to care for  
 19 beneficiaries under the medicare program under title  
 20 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)  
 21 that reside in a rural area.

22 “(b) ELIGIBLE SMALL RURAL HOSPITAL DE-  
 23 FINED.—For purposes of this paragraph, the term ‘eligi-  
 24 ble small rural hospital’ means a non-Federal, short-term  
 25 general acute care hospital that—

1           “(1) is located in a rural area (as defined for  
2           purposes of section 1886(d) of the Social Security  
3           Act (42 U.S.C. 1395ww(d))); and

4           “(2) has less than 50 beds.

5           “(c) APPLICATION AND APPROVAL.—

6           “(1) APPLICATION.—Each eligible small rural  
7           hospital that desires to receive a grant under this  
8           paragraph shall submit an application to the Sec-  
9           retary, at such time, in such form and manner, and  
10          accompanied by such additional information as the  
11          Secretary may reasonably require.

12          “(2) APPROVAL.—The Secretary shall approve  
13          applications submitted under paragraph (1) based  
14          on a methodology developed by the Secretary in con-  
15          sultation with the Office of Rural Health Policy.

16          “(d) AMOUNT OF GRANT.—A grant to an eligible  
17          small rural hospital under this paragraph may not exceed  
18          \$250,000.

19          “(e) USE OF FUNDS.—

20          “(1) IN GENERAL.—Except as provided in para-  
21          graph (2), an eligible small rural hospital may use  
22          amounts received under a grant under this section to  
23          temporarily offset financial operating losses, with  
24          emphasis on those losses attributable to reimburse-  
25          ment formula changes that resulted from the Bal-

1       anced Budget Act of 1997, in order to ensure con-  
 2       tinued operation and short-term sustainability or to  
 3       address emergency physical capital needs that might  
 4       otherwise result in closure.

5               “(2) PROHIBITED USES.—A hospital may not  
 6       use funds received under a grant under this section  
 7       for new construction, the purchase of medical equip-  
 8       ment, or for computer software or hardware.

9       “(f) REPORT.—

10              “(1) INFORMATION.—A hospital receiving a  
 11       grant under this section shall furnish the Secretary  
 12       with such information as the Secretary may require  
 13       to evaluate the project for which the grant is made  
 14       and to ensure that the grant is expended for the  
 15       purposes for which it is made.

16              “(2) REPORTING.—

17                      “(A) ANNUAL REPORTS.—

18                              “(i) IN GENERAL.—Not later than  
 19                      December 31 of each year (beginning with  
 20                      2001), the Secretary shall submit a report  
 21                      to the committees of jurisdiction of the  
 22                      House of Representatives and the Senate  
 23                      on the grant program established under  
 24                      this section.



1                   “(ii) INFORMATION INCLUDED.—The  
 2                   report submitted under clause (i) shall in-  
 3                   clude information on the number of grants  
 4                   made, the nature of the projects involved,  
 5                   the geographic distribution of grant recipi-  
 6                   ents, and such other information as the  
 7                   Secretary determines is appropriate.

8                   “(B) FINAL REPORT.—Not later than 180  
 9                   days after the completion of all of the projects  
 10                  for which a grant is made under this section,  
 11                  the Secretary shall submit a final report on the  
 12                  grant program established under this section to  
 13                  the committees described in subparagraph (A).

14                  “(g) APPROPRIATIONS.—There are appropriated, out  
 15                  of any money in the Treasury not otherwise appropriated,  
 16                  for making grants under this section \$25,000,000 for each  
 17                  of the fiscal years 2001 through 2005.”.

18   **SEC. 450. REFINEMENT OF MEDICARE REIMBURSEMENT**  
 19                   **FOR TELEHEALTH SERVICES.**

20                  (a) REVISION OF TELEHEALTH PAYMENT METHOD-  
 21                  OLOGY AND ELIMINATION OF FEE-SHARING REQUIRE-  
 22                  MENT.—Section 4206(b) of the Balanced Budget Act of  
 23                  1997 (42 U.S.C. 1395l note) is amended to read as fol-  
 24                  lows:

1       “(b) METHODOLOGY FOR DETERMINING AMOUNT OF  
2 PAYMENTS.—

3               “(1) IN GENERAL.—The Secretary shall pay  
4 to—

5                       “(A) the physician or practitioner at a dis-  
6 tant site that provides an item or service under  
7 subsection (a) an amount equal to the amount  
8 that such physician or provider would have been  
9 paid had the item or service been provided with-  
10 out the use of a telecommunications system;  
11 and

12                      “(B) the originating site a facility fee for  
13 facility services furnished in connection with  
14 such item or service.

15               “(2) APPLICATION OF PART B COINSURANCE  
16 AND DEDUCTIBLE.—Any payment made under this  
17 section shall be subject to the coinsurance and de-  
18 ductible requirements under subsections (a)(1) and  
19 (b) of section 1833 of the Social Security Act (42  
20 U.S.C. 1395l).

21               “(3) DEFINITIONS.—In this subsection:

22                      “(A) DISTANT SITE.—The term ‘distant  
23 site’ means the site at which the physician or  
24 practitioner is located at the time the item or

1 service is provided via a telecommunications  
2 system.

3 “(B) FACILITY FEE.—The term ‘facility  
4 fee’ means an amount equal to—

5 “(i) for 2000 and 2001, \$20; and

6 “(ii) for a subsequent year, the facil-  
7 ity fee under this subsection for the pre-  
8 vious year increased by the percentage in-  
9 crease in the MEI (as defined in section  
10 1842(i)(3)) for such subsequent year.

11 “(C) ORIGINATING SITE.—

12 “(i) IN GENERAL.—The term ‘origi-  
13 nating site’ means the site described in  
14 clause (ii) at which the eligible telehealth  
15 beneficiary under the medicare program is  
16 located at the time the item or service is  
17 provided via a telecommunications system.

18 “(ii) SITES DESCRIBED.—The sites  
19 described in this paragraph are as follows:

20 “(I) On or before January 1,  
21 2002, the office of a physician or a  
22 practitioner, a critical access hospital,  
23 a rural health clinic, and a Federally  
24 qualified health center.

1                   “(II) On or before January 1,  
 2                   2003, a hospital, a skilled nursing fa-  
 3                   cility, a comprehensive outpatient re-  
 4                   habilitation facility, a renal dialysis  
 5                   facility, an ambulatory surgical center,  
 6                   an Indian Health Service facility, and  
 7                   a community mental health center.”.

8           (b) ELIMINATION OF REQUIREMENT FOR TELEPRE-  
 9   SENDER.—Section 4206 of the Balanced Budget Act of  
 10 1997 (42 U.S.C. 1395l note) is amended—

11           (1) in subsection (a), by striking “, notwith-  
 12           standing that the individual physician” and all that  
 13           follows before the period at the end; and

14           (2) by adding at the end the following new sub-  
 15           section:

16           “(e) TELEPRESENTER NOT REQUIRED.—Nothing in  
 17           this section shall be construed as requiring an eligible tele-  
 18           health beneficiary to be presented by a physician or practi-  
 19           tioner for the provision of an item or service via a tele-  
 20           communications system.”.

21           (c) REIMBURSEMENT FOR MEDICARE BENE-  
 22   FICIARIES WHO DO NOT RESIDE IN A HPSA.—Section  
 23 4206(a) of the Balanced Budget Act of 1997 (42 U.S.C.  
 24 1395l note), as amended by subsection (b), is amended—

1           (1) by striking “IN GENERAL.—Not later than”  
 2           and inserting the following: “TELEHEALTH SERV-  
 3           ICES REIMBURSED.—

4           “(1) IN GENERAL.—Not later than”;

5           (2) by striking “furnishing a service for which  
 6           payment” and all that follows before the period and  
 7           inserting “to an eligible telehealth beneficiary”; and

8           (3) by adding at the end the following new  
 9           paragraph:

10           “(2) ELIGIBLE TELEHEALTH BENEFICIARY DE-  
 11           FINED.—In this section, the term ‘eligible telehealth  
 12           beneficiary’ means a beneficiary under the medicare  
 13           program under title XVIII of the Social Security Act  
 14           (42 U.S.C. 1395 et seq.) that resides in—

15           “(A) an area that is designated as a health  
 16           professional shortage area under section  
 17           332(a)(1)(A) of the Public Health Service Act  
 18           (42 U.S.C. 254e(a)(1)(A));

19           “(B) a county that is not included in a  
 20           Metropolitan Statistical Area; or

21           “(C) an inner-city area that is medically  
 22           underserved (as defined in section 330(b)(3) of  
 23           the Public Health Service Act (42 U.S.C.  
 24           254b(b)(3))).”.

1 (d) TELEHEALTH COVERAGE FOR DIRECT PATIENT  
2 CARE.—

3 (1) IN GENERAL.—Section 4206 of the Bal-  
4 anced Budget Act of 1997 (42 U.S.C. 1395l note),  
5 as amended by subsection (c), is amended—

6 (A) in subsection (a)(1), by striking “pro-  
7 fessional consultation via telecommunications  
8 systems with a physician” and inserting “items  
9 and services for which payment may be made  
10 under such part that are furnished via a tele-  
11 communications system by a physician”; and

12 (B) by adding at the end the following new  
13 subsection:

14 “(f) COVERAGE OF ITEMS AND SERVICES.—Payment  
15 for items and services provided pursuant to subsection (a)  
16 shall include payment for professional consultations, office  
17 visits, office psychiatry services, including any service  
18 identified as of July 1, 2000, by HCPCS codes 99241–  
19 99275, 99201–99215, 90804–90815, and 90862.”.

20 (2) STUDY AND REPORT REGARDING ADDI-  
21 TIONAL ITEMS AND SERVICES.—

22 (A) STUDY.—The Secretary of Health and  
23 Human Services shall conduct a study to iden-  
24 tify items and services in addition to those de-  
25 scribed in section 4206(f) of the Balanced

1           Budget Act of 1997 (as added by paragraph  
2           (1)) that would be appropriate to provide pay-  
3           ment under title XVIII of the Social Security  
4           Act (42 U.S.C. 1395 et seq.).

5           (B) REPORT.—Not later than 2 years after  
6           the date of enactment of this Act, the Secretary  
7           shall submit a report to Congress on the study  
8           conducted under subparagraph (A) together  
9           with such recommendations for legislation that  
10          the Secretary determines are appropriate.

11          (e) ALL PHYSICIANS AND PRACTITIONERS ELIGIBLE  
12          FOR TELEHEALTH REIMBURSEMENT.—Section 4206(a)  
13          of the Balanced Budget Act of 1997 (42 U.S.C. 1395l  
14          note), as amended by subsection (d), is amended—

15               (1) in paragraph (1), by striking “(described in  
16               section 1842(b)(18)(C) of such Act (42 U.S.C.  
17               1395u(b)(18)(C))”; and

18               (2) by adding at the end the following new  
19               paragraph:

20                       “(3) PRACTITIONER DEFINED.—For purposes  
21                       of paragraph (1), the term ‘practitioner’ includes—

22                               “(A) a practitioner described in section  
23                               1842(b)(18)(C) of the Social Security Act (42  
24                               U.S.C. 1395u(b)(18)(C)); and

1                   “(B) a physical, occupational, or speech  
2                   therapist.”.

3           (f) TELEHEALTH SERVICES PROVIDED USING  
4 STORE-AND-FORWARD           TECHNOLOGIES.—Section  
5 4206(a)(1) of the Balanced Budget Act of 1997 (42  
6 U.S.C. 1395l note), as amended by subsection (e), is  
7 amended by adding at the end the following new para-  
8 graph:

9                   “(4) USE OF STORE-AND-FORWARD TECH-  
10           NOLOGIES.—For purposes of paragraph (1), in the  
11           case of any Federal telemedicine demonstration pro-  
12           gram in Alaska or Hawaii, the term ‘telecommuni-  
13           cations system’ includes store-and-forward tech-  
14           nologies that provide for the asynchronous trans-  
15           mission of health care information in single or multi-  
16           media formats.”.

17           (g) CONSTRUCTION RELATING TO HOME HEALTH  
18 SERVICES.—Section 4206(a) of the Balanced Budget Act  
19 of 1997 (42 U.S.C. 1395l note), as amended by subsection  
20 (f), is amended by adding at the end the following new  
21 paragraph:

22                   “(5) CONSTRUCTION RELATING TO HOME  
23           HEALTH SERVICES.—

24                   “(A) IN GENERAL.—Nothing in this sec-  
25           tion or in section 1895 of the Social Security



1 Act (42 U.S.C. 1395fff) shall be construed as  
2 preventing a home health agency that is receiv-  
3 ing payment under the prospective payment  
4 system described in such section from fur-  
5 nishing a home health service via a tele-  
6 communications system.

7 “(B) LIMITATION.—The Secretary shall  
8 not consider a home health service provided in  
9 the manner described in subparagraph (A) to  
10 be a home health visit for purposes of—

11 “(i) determining the amount of pay-  
12 ment to be made under the prospective  
13 payment system established under section  
14 1895 of the Social Security Act (42 U.S.C.  
15 1395fff); or

16 “(ii) any requirement relating to the  
17 certification of a physician required under  
18 section 1814(a)(2)(C) of such Act (42  
19 U.S.C. 1395f(a)(2)(C)).”.

20 (h) FIVE-YEAR APPLICATION.—The amendments  
21 made by this section shall apply to items and services pro-  
22 vided on or after April 1, 2001, and before April 1, 2006.

1 **SEC. 451. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**  
2 **RURAL HEALTH CARE PROVIDERS.**

3 (a) STUDY.—The Medicare Payment Advisory Com-  
4 mission established under section 1805 of the Social Secu-  
5 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
6 as “MedPAC”) shall conduct a study on the effect of low  
7 patient and procedure volume on the financial status of  
8 low-volume, isolated rural health care providers partici-  
9 pating in the medicare program under title XVIII of the  
10 Social Security Act (42 U.S.C. 1395 et seq.).

11 (b) REPORT.—Not later than 18 months after the  
12 date of enactment of this Act, MedPAC shall submit a  
13 report to the Secretary of Health and Human Services and  
14 Congress on the study conducted under subsection (a)  
15 indicating—

16 (1) whether low-volume, isolated rural health  
17 care providers are having, or may have, significantly  
18 decreased medicare margins or other financial dif-  
19 ficulties resulting from any of the payment meth-  
20 odologies described in subsection (c);

21 (2) whether the status as a low-volume, isolated  
22 rural health care provider should be designated  
23 under the medicare program and any criteria that  
24 should be used to qualify for such a status; and

25 (3) any changes in the payment methodologies  
26 described in subsection (c) that are necessary to pro-

1       vide appropriate reimbursement under the medicare  
2       program to low-volume, isolated rural health care  
3       providers (as designated pursuant to paragraph (2)).

4       (c) PAYMENT METHODOLOGIES DESCRIBED.—The  
5       payment methodologies described in this subsection are  
6       the following:

7               (1) The prospective payment system for hos-  
8       pital outpatient department services under section  
9       1833(t) of the Social Security Act (42 U.S.C.  
10      1395l).

11              (2) The fee schedule for ambulance services  
12      under section 1834(l) of such Act (42 U.S.C.  
13      1395m(l)).

14              (3) The prospective payment system for inpa-  
15      tient hospital services under section 1886 of such  
16      Act (42 U.S.C. 1395ww).

17              (4) The prospective payment system for routine  
18      service costs of skilled nursing facilities under sec-  
19      tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

20              (5) The prospective payment system for home  
21      health services under section 1895 of such Act (42  
22      U.S.C. 1395fff).

1 **TITLE V—PROVISIONS RELAT-**  
 2 **ING TO PART C**  
 3 **(MEDICARE+CHOICE PRO-**  
 4 **GRAM) AND OTHER MEDI-**  
 5 **CARE MANAGED CARE PROVI-**  
 6 **SIONS**

7 **SEC. 501. RESTORING EFFECTIVE DATE OF ELECTIONS AND**  
 8 **CHANGES OF ELECTIONS OF**  
 9 **MEDICARE+CHOICE PLANS.**

10 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42  
 11 U.S.C. 1395w–21(f)(2)) is amended by striking “, except  
 12 that if such election or change is made after the 10th day  
 13 of any calendar month, then the election or change shall  
 14 not take effect until the first day of the second calendar  
 15 month following the date on which the election or change  
 16 is made”.

17 (b) EFFECTIVE DATE.—The amendment made by  
 18 this section shall apply to elections and changes of cov-  
 19 erage made on or after January 1, 2001.

20 **SEC. 502. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**  
 21 **NATION PROVISION FOR CERTAIN BENE-**  
 22 **FICIARIES.**

23 (a) DISENROLLMENT WINDOW IN ACCORDANCE  
 24 WITH BENEFICIARY’S CIRCUMSTANCE.—Section  
 25 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

1           (1) in subparagraph (A), in the matter fol-  
 2           lowing clause (iii), by striking “, subject to subpara-  
 3           graph (E), seeks to enroll under the policy not later  
 4           than 63 days after the date of termination of enroll-  
 5           ment described in such subparagraph” and inserting  
 6           “seeks to enroll under the policy during the period  
 7           specified in subparagraph (E)”; and

8           (2) by striking subparagraph (E) and inserting  
 9           the following new subparagraph:

10          “(E) For purposes of subparagraph (A), the time pe-  
 11          riod specified in this subparagraph is—

12               “(i) in the case of an individual described in  
 13               subparagraph (B)(i), the period beginning on the  
 14               date the individual receives a notice of termination  
 15               or cessation of all supplemental health benefits (or,  
 16               if no such notice is received, notice that a claim has  
 17               been denied because of such a termination or ces-  
 18               sation) and ending on the date that is 63 days after  
 19               the applicable notice;

20               “(ii) in the case of an individual described in  
 21               clause (ii), (iii), (v), or (vi) of subparagraph (B)  
 22               whose enrollment is terminated involuntarily, the pe-  
 23               riod beginning on the date that the individual re-  
 24               ceives a notice of termination and ending on the

1 date that is 63 days after the date the applicable  
2 coverage is terminated;

3 “(iii) in the case of an individual described in  
4 subparagraph (B)(iv)(I), the period beginning on the  
5 earlier of (I) the date that the individual receives a  
6 notice of termination, a notice of the issuer’s bank-  
7 ruptcy or insolvency, or other such similar notice, if  
8 any, and (II) the date that the applicable coverage  
9 is terminated, and ending on the date that is 63  
10 days after the date the coverage is terminated;

11 “(iv) in the case of an individual described in  
12 clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-  
13 paragraph (B) who disenrolls voluntarily, the period  
14 beginning on the date that is 60 days before the ef-  
15 fective date of the disenrollment and ending on the  
16 date that is 63 days after such effective date; and

17 “(v) in the case of an individual described in  
18 subparagraph (B) but not described in the preceding  
19 provisions of this subparagraph, the period begin-  
20 ning on the effective date of the disenrollment and  
21 ending on the date that is 63 days after such effec-  
22 tive date.”.

23 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED  
24 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.

1 1395ss(s)(3)), as amended by subsection (a), is amended  
2 by adding at the end the following new subparagraph:

3 “(F) For purposes of this paragraph—

4 “(i) in the case of an individual described in  
5 subparagraph (B)(v) (or deemed to be so described,  
6 pursuant to this subparagraph) whose enrollment  
7 with an organization or provider described in sub-  
8 clause (II) of such subparagraph is involuntarily ter-  
9 minated within the first 12 months of such enroll-  
10 ment, and who, without an intervening enrollment,  
11 enrolls with another such organization or provider,  
12 such subsequent enrollment shall be deemed to be an  
13 initial enrollment described in such subparagraph;  
14 and

15 “(ii) in the case of an individual described in  
16 clause (vi) of subparagraph (B) (or deemed to be so  
17 described, pursuant to this subparagraph) whose en-  
18 rollment with a plan or in a program described in  
19 clause (v)(II) of such subparagraph is involuntarily  
20 terminated within the first 12 months of such enroll-  
21 ment, and who, without an intervening enrollment,  
22 enrolls in another such plan or program, such subse-  
23 quent enrollment shall be deemed to be an initial en-  
24 rollment described in clause (vi) of such subpara-  
25 graph.”.

1 **SEC. 503. INCREASE IN NATIONAL PER CAPITA**  
2 **MEDICARE+CHOICE GROWTH PERCENTAGE**  
3 **IN 2001 AND 2002.**

4 Section 1853(c)(6)(B) of the Social Security Act (42  
5 U.S.C. 1395w-23(c)(6)(B)) is amended—

6 (1) in clause (iv), by striking “for 2001, 0.5  
7 percentage points” and inserting “for 2001, 0 per-  
8 centage points”; and

9 (2) in clause (v), by striking “for 2002, 0.3 per-  
10 centage points” and inserting “for 2002, 0 percent-  
11 age points”.

12 **SEC. 504. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**  
13 **IN 2002.**

14 Section 1853(c)(2) of the Social Security Act (42  
15 U.S.C. 1395w-23(c)(2)) is amended—

16 (1) by striking the period at the end of sub-  
17 paragraph (F) and inserting a semicolon; and

18 (2) by adding after and below subparagraph  
19 (F) the following:

20 “except that a Medicare+Choice organization may  
21 elect to apply subparagraph (F) (rather than sub-  
22 paragraph (E)) for 2002.”.



1 **SEC. 505. DELAY FROM JULY TO NOVEMBER 2000, IN DEAD-**  
 2 **LINE FOR OFFERING AND WITHDRAWING**  
 3 **MEDICARE+CHOICE PLANS FOR 2001.**

4 Notwithstanding any other provision of law, the dead-  
 5 line for a Medicare+Choice organization to withdraw the  
 6 offering of a Medicare+Choice plan under part C of title  
 7 XVIII of the Social Security Act (or otherwise to submit  
 8 information required for the offering of such a plan) for  
 9 2001 is delayed from July 1, 2000, to November 1, 2000,  
 10 and any such organization that provided notice of with-  
 11 drawal of such a plan during 2000 before the date of en-  
 12 actment of this Act may rescind such withdrawal at any  
 13 time before November 1, 2000.

14 **SEC. 506. AMOUNTS IN MEDICARE TRUST FUNDS AVAIL-**  
 15 **ABLE FOR SECRETARY'S SHARE OF**  
 16 **MEDICARE+CHOICE EDUCATION AND EN-**  
 17 **ROLLMENT-RELATED COSTS.**

18 (a) RELOCATION OF PROVISIONS.—Section  
 19 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to  
 20 read as follows:

21 “(2) COST-SHARING IN ENROLLMENT-RELATED  
 22 COSTS.—A Medicare+Choice organization shall pay  
 23 the fee established by the Secretary under section  
 24 1851(j)(3)(A).”.

25 (b) FUNDING FOR EDUCATION AND ENROLLMENT  
 26 ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is

1 amended by adding at the end the following new sub-  
 2 section:

3 “(j) FUNDING FOR BENEFICIARY EDUCATION AND  
 4 ENROLLMENT ACTIVITIES.—

5 “(1) SECRETARY’S ESTIMATE OF TOTAL  
 6 COSTS.—The Secretary shall annually estimate the  
 7 total cost for a fiscal year of carrying out this sec-  
 8 tion, section 4360 of the Omnibus Budget Reconcili-  
 9 ation Act of 1990 (relating to the health insurance  
 10 counseling and assistance program), and related ac-  
 11 tivities.

12 “(2) TOTAL AMOUNT AVAILABLE.—The total  
 13 amount available to the Secretary for a fiscal year  
 14 for the costs of the activities described in paragraph  
 15 (1) shall be equal to the lesser of—

16 “(A) the amount estimated for such fiscal  
 17 year under paragraph (1); or

18 “(B) for—

19 “(i) fiscal year 2001, \$130,000,000;  
 20 and

21 “(ii) fiscal year 2002 and each subse-  
 22 quent fiscal year, the amount for the pre-  
 23 vious fiscal year, adjusted to account for  
 24 inflation, any change in the number of

1 beneficiaries under this title, and any other  
 2 relevant factors.

3 “(3) COST-SHARING IN ENROLLMENT-RELATED  
 4 COSTS.—

5 “(A) AMOUNTS FROM MEDICARE+CHOICE  
 6 ORGANIZATIONS.—

7 “(i) IN GENERAL.—The Secretary is  
 8 authorized to charge a fee to each  
 9 Medicare+Choice organization with a con-  
 10 tract under this part that is equal to the  
 11 organization’s pro rata share (as deter-  
 12 mined by the Secretary) of the  
 13 Medicare+Choice portion (as defined in  
 14 clause (ii)) of the total amount available  
 15 under paragraph (2) for a fiscal year. Any  
 16 amounts collected shall be available with-  
 17 out further appropriation to the Secretary  
 18 for the costs of the activities described in  
 19 paragraph (1).

20 “(ii) MEDICARE+CHOICE PORTION  
 21 DEFINED.—For purposes of clause (i), the  
 22 term ‘Medicare+Choice portion’ means, for  
 23 a fiscal year, the ratio, as estimated by the  
 24 Secretary, of—

1 “(I) the average number of indi-  
2 viduals enrolled in Medicare+Choice  
3 plans during the fiscal year; to

4 “(II) the average number of indi-  
5 viduals entitled to benefits under  
6 parts A, and enrolled under part B,  
7 during the fiscal year.

8 “(B) SECRETARY’S SHARE.—

9 “(i) AMOUNTS AVAILABLE FROM  
10 TRUST FUNDS.—The Secretary’s share of  
11 expenses shall be payable from funds in  
12 the Federal Hospital Insurance Trust  
13 Fund and the Federal Supplementary  
14 Medical Insurance Trust Fund, in such  
15 proportion as the Secretary shall deem to  
16 be fair and equitable after taking into con-  
17 sideration the expenses attributable to the  
18 administration of this part with respect to  
19 part A and B. The Secretary shall make  
20 such transfers of moneys between such  
21 Trust Funds as may be appropriate to set-  
22 tle accounts between the Trust Funds in  
23 cases where expenses properly payable  
24 from one such Trust Fund have been paid  
25 from the other such Trust Fund.

1 “(ii) SECRETARY’S SHARE OF EX-  
 2 PENSES DEFINED.—For purposes of clause  
 3 (i), the term ‘Secretary’s share of ex-  
 4 penses’ means, for a fiscal year, an amount  
 5 equal to—

6 “(I) the total amount available to  
 7 the Secretary under paragraph (2) for  
 8 the fiscal year; less

9 “(II) the amount collected under  
 10 subparagraph (A) for the fiscal  
 11 year.”.

12 **SEC. 507. REVISED TERMS AND CONDITIONS FOR EXTEN-**  
 13 **SION OF MEDICARE COMMUNITY NURSING**  
 14 **ORGANIZATION (CNO) DEMONSTRATION**  
 15 **PROJECT.**

16 (a) IN GENERAL.—Section 532 of BBRA (42 U.S.C.  
 17 1395mm note) is amended—

18 (1) in subsection (a), by striking the second  
 19 sentence; and

20 (2) by striking subsection (b) and inserting the  
 21 following new subsections:

22 “(b) TERMS AND CONDITIONS.—

23 “(1) JANUARY THROUGH SEPTEMBER 2000.—  
 24 For the 9-month period beginning with January  
 25 2000, any such demonstration project shall be con-

1       ducted under the same terms and conditions as ap-  
 2       plied to such demonstration during 1999.

3           “(2)   OCTOBER   2000   THROUGH   DECEMBER  
 4       2001.—For the 15-month period beginning with Oc-  
 5       tober 2000, any such demonstration project shall be  
 6       conducted under the same terms and conditions as  
 7       applied to such demonstration during 1999, except  
 8       that the following modifications shall apply:

9           “(A)   BASIC   CAPITATION   RATE.—The basic  
 10       capitation rate paid for services covered under  
 11       the project (other than case management serv-  
 12       ices) per enrollee per month shall be basic capi-  
 13       tation rate paid for such services for 1999, re-  
 14       duced by 10 percent in the case of the dem-  
 15       onstration sites located in Arizona, Minnesota,  
 16       and Illinois, and 15 percent for the demonstra-  
 17       tion site located in New York.

18          “(B)   TARGETED   CASE   MANAGEMENT  
 19       FEE.—A case management fee shall be paid  
 20       only for enrollees who are classified as ‘mod-  
 21       erate’ or ‘at risk’ through a baseline health as-  
 22       sessment (as required for Medicare+Choice  
 23       plans under section 1852(e) of the Social Secu-  
 24       rity Act (42 U.S.C. 1395ww–22(e)).

1           “(C) GREATER UNIFORMITY IN CLINICAL  
2 FEATURES AMONG SITES.—Each project shall  
3 implement for each site—

4           “(i) protocols for periodic telephonic  
5 contact with enrollees based on—

6           “(I) the results of such standard-  
7 ized written health assessment; and

8           “(II) the application of appro-  
9 priate care planning approaches;

10          “(ii) disease management programs  
11 for targeted diseases (such as congestive  
12 heart failure, arthritis, diabetes, and hy-  
13 pertension) that are highly prevalent in the  
14 enrolled populations;

15          “(iii) systems and protocols to track  
16 enrollees through hospitalizations, includ-  
17 ing pre-admission planning, concurrent  
18 management during inpatient hospital  
19 stays, and post-discharge assessment, plan-  
20 ning, and follow-up; and

21          “(iv) standardized patient educational  
22 materials for specified diseases and health  
23 conditions.

1                   “(D)    QUALITY    IMPROVEMENT.—Each  
2                   project shall implement at each site once during  
3                   the 15-month period—

4                           “(i) enrollee satisfaction surveys; and

5                           “(ii) reporting on specified quality in-  
6                   dicators for the enrolled population.

7                   “(c) EVALUATION.—

8                           “(1) PRELIMINARY REPORT.—Not later than  
9                   July 1, 2001, the Secretary of Health and Human  
10                  Services shall submit to the Committees on Ways  
11                  and Means and Commerce of the House of Rep-  
12                  resentatives and the Committee on Finance of the  
13                  Senate a preliminary report that—

14                           “(A) evaluates such demonstration projects  
15                  for the period beginning July 1, 1997, and end-  
16                  ing December 31, 1999, on a site-specific basis  
17                  with respect to the impact on per beneficiary  
18                  spending, specific health utilization measures,  
19                  and enrollee satisfaction; and

20                           “(B) includes a similar evaluation of such  
21                  projects for the portion of the extension period  
22                  that occurs after September 30, 2000.

23                           “(2) FINAL REPORT.—Not later than July 1,  
24                  2002, the Secretary shall submit a final report to  
25                  such Committees on such demonstration projects.



1 Such report shall include the same elements as the  
 2 preliminary report required by paragraph (1), but  
 3 for the period after December 31, 1999.

4 “(3) METHODOLOGY FOR SPENDING COMPARI-  
 5 SONS.—Any evaluation of the impact of the dem-  
 6 onstration projects on per beneficiary spending in-  
 7 cluded in such reports shall be based on a compari-  
 8 son of—

9 “(A) data for all individuals who—

10 “(i) were enrolled in such demonstra-  
 11 tion projects as of the first day of the pe-  
 12 riod under evaluation; and

13 “(ii) were enrolled for a minimum of  
 14 6 months thereafter; with

15 “(B) data for a matched sample of individ-  
 16 uals who are enrolled under part B of title  
 17 XVIII of the Social Security Act (42 U.S.C.  
 18 1395j et seq.) and who are not enrolled in such  
 19 a project, in a Medicare+Choice plan under  
 20 part C of such title (42 U.S.C. 1395w-21 et  
 21 seq.), a plan offered by an eligible organization  
 22 under section 1876 of such Act (42 U.S.C.  
 23 1395mm), or a health care prepayment plan  
 24 under section 1833(a)(1)(A) of such Act (42  
 25 U.S.C. 1395l(a)(1)(A)).”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 subsection (a) shall be effective as if included in the enact-  
 3 ment of section 532 of BBRA (42 U.S.C. 1395mm note).

4 **SEC. 508. MODIFICATION OF PAYMENT RULES FOR CER-**  
 5 **TAIN FRAIL ELDERLY MEDICARE BENE-**  
 6 **FICIARIES.**

7 (a) MODIFICATION OF PAYMENT RULES.—Section  
 8 1853 (42 U.S.C. 1395w–23) is amended—

9 (1) in subsection (a)—

10 (A) in paragraph (1)(A), by striking “sub-  
 11 sections (e), (g), and (i)” and inserting “sub-  
 12 sections (e), (g), (i), and (j)”;

13 (B) in paragraph (3)(D), by inserting  
 14 “paragraph (4) and” after “Subject to”; and

15 (C) by adding at the end the following new  
 16 paragraph:

17 “(4) EXEMPTION FROM RISK-ADJUSTMENT SYS-  
 18 TEM FOR FRAIL ELDERLY BENEFICIARIES EN-  
 19 ROLLED IN SPECIALIZED PROGRAMS.—

20 “(A) IN GENERAL.—In applying the risk-  
 21 adjustment factors established under paragraph  
 22 (3) during the period described in subparagraph  
 23 (B), the limitation under paragraph  
 24 (3)(C)(ii)(I) shall apply to a frail elderly  
 25 Medicare+Choice beneficiary (as defined in

1 subsection (j)(3)) who is enrolled in a  
 2 Medicare+Choice plan under a specialized pro-  
 3 gram for the frail elderly (as defined in sub-  
 4 section (j)(2)) during the entire period.

5 “(B) PERIOD OF APPLICATION.—The pe-  
 6 riod described in this subparagraph begins with  
 7 January 2001, and ends with the first month  
 8 for which the Secretary certifies to Congress  
 9 that a comprehensive risk adjustment method-  
 10 ology under paragraph (3)(C) that takes into  
 11 account the factors described in subsection  
 12 (j)(1)(B) is being fully implemented.”; and  
 13 (2) by adding at the end the following new sub-  
 14 section:

15 “(j) SPECIAL RULES FOR FRAIL ELDERLY EN-  
 16 ROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL EL-  
 17 DERLY.—

18 “(1) DEVELOPMENT AND IMPLEMENTATION OF  
 19 NEW PAYMENT SYSTEM.—

20 “(A) IN GENERAL.—The Secretary shall  
 21 develop and implement (as soon as possible  
 22 after the date of enactment of the Medicare,  
 23 Medicaid, and SCHIP Balanced Budget Refine-  
 24 ment Act of 2000), during the period described  
 25 in subsection (a)(4)(B), a payment methodology

1 for frail elderly Medicare+Choice beneficiaries  
 2 enrolled in a Medicare+Choice plan under a  
 3 specialized program for the frail elderly (as de-  
 4 fined in paragraph (2)(A)).

5 “(B) FACTORS DESCRIBED.—The method-  
 6 ology developed and implemented under sub-  
 7 paragraph (A) shall take into account the prev-  
 8 alence, mix, and severity of chronic conditions  
 9 among frail elderly Medicare+Choice bene-  
 10 ficiaries and shall include—

11 “(i) medical diagnostic factors from  
 12 all provider settings (including hospital  
 13 and nursing facility settings);

14 “(ii) functional indicators of health  
 15 status; and

16 “(iii) such other factors as may be  
 17 necessary to achieve appropriate payments  
 18 for plans serving such beneficiaries.

19 “(2) SPECIALIZED PROGRAM FOR THE FRAIL  
 20 ELDERLY DEFINED.—

21 “(A) IN GENERAL.—In this part, the term  
 22 ‘specialized program for the frail elderly’ means  
 23 a program that the Secretary determines—

24 “(i) is offered under this part as a  
 25 distinct part of a Medicare+Choice plan;

1 “(ii) primarily enrolls frail elderly  
 2 Medicare+Choice beneficiaries; and

3 “(iii) has a clinical delivery system  
 4 that is specifically designed to serve the  
 5 special needs of such beneficiaries and to  
 6 coordinate short-term and long-term care  
 7 for such beneficiaries through the use of a  
 8 team described in subparagraph (B) and  
 9 through the provision of primary care serv-  
 10 ices to such beneficiaries by means of such  
 11 a team at the nursing facility involved.

12 “(B) SPECIALIZED TEAM DESCRIBED.—A  
 13 team described in this subparagraph—

14 “(i) includes—

15 “(I) a physician; and

16 “(II) a nurse practitioner or geri-  
 17 atric care manager; and

18 “(ii) has as members individuals  
 19 who—

20 “(I) have special training in the  
 21 care and management of the frail el-  
 22 derly beneficiaries; and

23 “(II) specialize in the care and  
 24 management of such beneficiaries.

1           “(3) FRAIL ELDERLY MEDICARE+CHOICE BEN-  
 2           EFICIARY DEFINED.—In this part, the term ‘frail el-  
 3           derly Medicare+Choice beneficiary’ means a  
 4           Medicare+Choice eligible individual who—

5                   “(A) is residing in a skilled nursing facility  
 6                   (as defined in section 1819(a)) or a nursing fa-  
 7                   cility (as defined in section 1919(a)) for an in-  
 8                   definite period and without any intention of re-  
 9                   siding outside the facility; and

10                   “(B) has a severity of condition that  
 11                   makes the individual frail (as determined under  
 12                   guidelines approved by the Secretary).”.

13           (b) EFFECTIVE DATE.—The amendments made by  
 14           this section shall take effect on the date of enactment of  
 15           this Act.

## 16   **TITLE VI—PROVISIONS RELAT-** 17       **ING TO INDIVIDUALS WITH** 18       **END-STAGE RENAL DISEASE**

### 19   **SEC. 601. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

20           (a) IN GENERAL.—The last sentence of section  
 21           1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by strik-  
 22           ing “, and for such services” and all that follows before  
 23           the period at the end and inserting the following: “, for  
 24           such services furnished during 2001, by 2.4 percent above  
 25           such composite rate payment amounts for such services

1 furnished on December 31, 2000, for such services fur-  
 2 nished during 2002 and 2003, by the percentage increase  
 3 in the Consumer Price Index for all urban consumers  
 4 (U.S. city average) for the 12-month period ending with  
 5 June of the previous year above such composite rate pay-  
 6 ment amounts for such services furnished on December  
 7 31 of the previous year, and for such services furnished  
 8 during a subsequent year, by the ESRD market basket  
 9 percentage increase above such composite rate payment  
 10 amounts for such services furnished on December 31 of  
 11 the previous year”.

12 (b) ESRD MARKET BASKET PERCENTAGE INCREASE  
 13 DEFINED.—Section 1881(b) (42 U.S.C. 1395rr(b)) is  
 14 amended by adding at the end the following new para-  
 15 graph:

16 “(12)(A) For purposes of this title, the term ‘ESRD  
 17 market basket percentage increase’ means, with respect to  
 18 a calendar year, the percentage (estimated by the Sec-  
 19 retary before the beginning of such year) by which—

20 “(i) the cost of the mix of goods and services  
 21 included in the provision of dialysis services (which  
 22 may include the costs described in subparagraph (D)  
 23 as determined appropriate by the Secretary) that is  
 24 determined based on an index of appropriately  
 25 weighted indicators of changes in wages and prices

1       which are representative of the mix of goods and  
2       services included in such dialysis services for the cal-  
3       endar year; exceeds

4               “(ii) the cost of such mix of goods and services  
5       for the preceding calendar year.

6       “(B) In determining the percentage under subpara-  
7       graph (A), the Secretary may take into account any in-  
8       crease in the costs of furnishing the mix of goods and serv-  
9       ices described in such subparagraph resulting from—

10              “(i) the adoption of scientific and technological  
11       innovations used to provide dialysis services; and

12              “(ii) changes in the manner or method of deliv-  
13       ering dialysis services.

14       “(C) The Secretary shall periodically review and up-  
15       date (as necessary) the items and services included in the  
16       mix of goods and services used to determine the percent-  
17       age under subparagraph (A).

18       “(D) The costs described in this subparagraph  
19       include—

20              “(i) labor, including direct patient care costs  
21       and administrative labor costs, vacation and holiday  
22       pay, payroll taxes, and employee benefits;

23              “(ii) other direct costs, including drugs, sup-  
24       plies, and laboratory fees;



1           “(iii) overhead, including medical director fees,  
2           temporary services, general and administrative costs,  
3           interest expenses, and bad debt;

4           “(iv) capital, including rent, real estate taxes,  
5           depreciation, utilities, repairs, and maintenance; and

6           “(v) such other allowable costs as the Secretary  
7           may specify.”.

8   **SEC. 602. REVISION OF PAYMENT RATES FOR ESRD PA-**  
9                           **TIENTS ENROLLED IN MEDICARE+CHOICE**  
10                          **PLANS.**

11           (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.  
12   1395w–23(a)(1)(B)) is amended by adding at the end the  
13   following: “In establishing such rates the Secretary shall  
14   provide for appropriate adjustments to increase each rate  
15   to reflect the demonstration rate (including any risk-ad-  
16   justment associated with such rate) of the social health  
17   maintenance organization end-stage renal disease dem-  
18   onstrations established by section 2355 of the Deficit Re-  
19   duction Act of 1984 (Public Law 98–369; 98 Stat. 1103),  
20   as amended by section 13567(b) of the Omnibus Budget  
21   Reconciliation Act of 1993 (Public Law 103–66; 107 Stat.  
22   608), and shall compute such rates by not taking into ac-  
23   count individuals with kidney transplants and individuals  
24   in which the program under this title is a secondary payer

1 to another payer (or payers) pursuant to section  
2 1862(b).”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to payments for months begin-  
5 ning with January 2002.

6 (c) PUBLICATION.—The Secretary of Health and  
7 Human Services, not later than 6 months after the date  
8 of enactment of this Act, shall publish for public comment  
9 a description of the appropriate adjustments described in  
10 the last sentence of section 1853(a)(1)(B) of the Social  
11 Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by  
12 subsection (a). The Secretary shall publish in final form  
13 such adjustments by not later than July 1, 2001, so that  
14 the amendment made by subsection (a) is implemented on  
15 a timely basis consistent with subsection (b).

16 **SEC. 603. PERMITTING ESRD BENEFICIARIES TO ENROLL**  
17 **IN ANOTHER MEDICARE+CHOICE PLAN IF**  
18 **THE PLAN IN WHICH THEY ARE ENROLLED IS**  
19 **TERMINATED.**

20 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.  
21 1395w–21(a)(3)(B)) is amended by striking “except that”  
22 and all that follows and inserting the following: “except  
23 that—

24 “(i) an individual who develops end-  
25 stage renal disease while enrolled in a

1 Medicare+Choice plan may continue to be  
 2 enrolled in that plan; and

3 “(ii) in the case of such an individual  
 4 who is enrolled in a Medicare+Choice plan  
 5 under clause (i) (or subsequently under  
 6 this clause), if the enrollment is discon-  
 7 tinued under circumstances described in  
 8 section 1851(e)(4)(A) then the individual  
 9 will be treated as a ‘Medicare+Choice eli-  
 10 gible individual’ for purposes of electing to  
 11 continue enrollment in another  
 12 Medicare+Choice plan.”.

13 (b) EFFECTIVE DATE.—

14 (1) IN GENERAL.—The amendment made by  
 15 subsection (a) shall apply to terminations and  
 16 discontinuations occurring on or after the date of  
 17 enactment of this Act.

18 (2) APPLICATION TO PRIOR PLAN TERMI-  
 19 NATIONS.—Clause (ii) of section 1851(a)(3)(B) of  
 20 the Social Security Act (as inserted by subsection  
 21 (a)) also shall apply to individuals whose enrollment  
 22 in a Medicare+Choice plan was terminated or dis-  
 23 continued after December 31, 1997, and before the  
 24 date of enactment of this Act. In applying this para-  
 25 graph, such an individual shall be treated, for pur-

1 poses of part C of title XVIII of the Social Security  
 2 Act, as having discontinued enrollment in such a  
 3 plan as of the date of enactment of this Act.

4 **SEC. 604. COVERAGE OF CERTAIN VASCULAR ACCESS SERV-**  
 5 **ICES FOR ESRD BENEFICIARIES PROVIDED**  
 6 **BY AMBULATORY SURGICAL CENTERS.**

7 (a) IN GENERAL.—The matter following subpara-  
 8 graph (B) of section 1833(i)(1) (42 U.S.C. 1395l(i)(1))  
 9 is amended by adding at the end the following new sen-  
 10 tence: “Such lists shall include the procedures identified  
 11 as of July 30, 1999, by vascular access codes 34101,  
 12 34111, 34490, 35190, 35458, 35460, 35475, 35476,  
 13 35903, 36005, 36010, 36011, 36120, 36140, 36145,  
 14 36215–36218, 36831–36834, 37201, 37204–37208,  
 15 37250, 37251, and 49423.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
 17 subsection (a) shall apply to vascular access services fur-  
 18 nished on or after January 1, 2000.

19 **SEC. 605. COLLECTION AND ANALYSIS OF INFORMATION**  
 20 **ON THE SATISFACTION OF ESRD BENE-**  
 21 **FICIARIES WITH THE QUALITY OF AND AC-**  
 22 **CESS TO HEALTH CARE UNDER THE MEDI-**  
 23 **CARE PROGRAM.**

24 (a) COLLECTION OF INFORMATION.—The Secretary  
 25 shall collect information on the satisfaction of each ESRD

1 medicare beneficiary with the quality of health care under  
2 the original fee-for-service medicare program and the  
3 Medicare+Choice program, and the access of each bene-  
4 ficiary to that care.

5 (b) ANALYSIS OF COLLECTED INFORMATION.—

6 (1) IN GENERAL.—The Secretary shall conduct  
7 an analysis of the information collected under sub-  
8 section (a) to determine—

9 (A) the kinds of health care that each non-  
10 dialysis health care provider provides to each  
11 ESRD medicare beneficiary for the treatment  
12 of end-stage renal disease and each comor-  
13 bidity;

14 (B) the effect of the availability of supple-  
15 mental insurance on the use by beneficiary of  
16 health care;

17 (C) the perceptions of each beneficiary re-  
18 garding the access of that beneficiary to health  
19 care; and

20 (D) the quality of health care provided to  
21 each ESRD medicare beneficiary enrolled under  
22 the Medicare+Choice program compared to  
23 each beneficiary enrolled under the original fee-  
24 for-service medicare program.

1           (2) CONSIDERATIONS.—In conducting the anal-  
2       ysis under paragraph (1), the Secretary shall  
3       consider—

4           (A) the feasibility of routinely collecting in-  
5       formation on the satisfaction of each ESRD  
6       medicare beneficiary with dialysis and non-di-  
7       alysis health care;

8           (B) whether to collect information using  
9       disease specific questions or generic questions  
10      (similar to those used in conducting the Medi-  
11      care Current Beneficiary Survey);

12          (C) how well collected information detects  
13      access problems within each specific group of  
14      ESRD medicare beneficiaries, including bene-  
15      ficiaries without supplemental insurance and  
16      beneficiaries that reside in a rural area; and

17          (D) each obstacle that a health care pro-  
18      vider may face in offering each type of dialysis  
19      service.

20      (c) AVAILABILITY OF INFORMATION AND ANAL-  
21      YSIS.—Not later than January 1 of each year (beginning  
22      in 2002) the Secretary shall make the information col-  
23      lected under subsection (a) and the analysis conducted  
24      under subsection (b) available to the public.

25      (d) DEFINITIONS.—In this section:

1           (1) ESRD MEDICARE BENEFICIARY.—The term  
2           “ESRD medicare beneficiary” means an individual  
3           eligible for benefits under the medicare program that  
4           has end-stage renal disease (including an individual  
5           enrolled in a Medicare+Choice plan offered by a  
6           Medicare+Choice organization under the  
7           Medicare+Choice program).

8           (2) MEDICARE+CHOICE PROGRAM.—The term  
9           “Medicare+Choice program” means the program es-  
10          tablished under part C of title XVIII of the Social  
11          Security Act (42 U.S.C. 1395w–21 et seq.).

12          (3) ORIGINAL FEE-FOR-SERVICE MEDICARE  
13          PROGRAM.—The term “original fee-for-service medi-  
14          care program” means the health benefits program  
15          under parts A and B title XVIII of the Social Secu-  
16          rity Act (42 U.S.C. 1395 et seq.).

17          (4) SECRETARY.—The term “Secretary” means  
18          the Secretary of Health and Human Services, acting  
19          through the Administrator of the Health Care Fi-  
20          nancing Administration.

1 **TITLE VII—ACCESS TO CARE IM-**  
 2 **PROVEMENTS THROUGH**  
 3 **MEDICAID AND SCHIP**

4 **SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**  
 5 **ERALLY-QUALIFIED HEALTH CENTERS AND**  
 6 **RURAL HEALTH CLINICS.**

7 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
 8 1396a(a)) is amended—

9 (1) in paragraph (13)—

10 (A) in subparagraph (A), by adding “and”  
 11 at the end;

12 (B) in subparagraph (B), by striking  
 13 “and” at the end; and

14 (C) by striking subparagraph (C); and

15 (2) by inserting after paragraph (14) the fol-  
 16 lowing new paragraph:

17 “(15) for payment for services described in sub-  
 18 paragraph (B) or (C) of section 1905(a)(2) under  
 19 the plan in accordance with subsection (aa);”.

20 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section  
 21 1902 (42 U.S.C. 1396a) is amended by adding at the end  
 22 the following:

23 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-  
 24 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL  
 25 HEALTH CLINICS.—



1           “(1) IN GENERAL.—Beginning with fiscal year  
2           2001 and each succeeding fiscal year, the State plan  
3           shall provide for payment for services described in  
4           section 1905(a)(2)(C) furnished by a Federally-  
5           qualified health center and services described in sec-  
6           tion 1905(a)(2)(B) furnished by a rural health clinic  
7           in accordance with the provisions of this subsection.

8           “(2) FISCAL YEAR 2001.—Subject to paragraph  
9           (4), for services furnished during fiscal year 2001,  
10          the State plan shall provide for payment for such  
11          services in an amount (calculated on a per visit  
12          basis) that is equal to 100 percent of the costs of  
13          the center or clinic of furnishing such services dur-  
14          ing fiscal year 2000 which are reasonable and re-  
15          lated to the cost of furnishing such services, or  
16          based on such other tests of reasonableness as the  
17          Secretary prescribes in regulations under section  
18          1833(a)(3), or, in the case of services to which such  
19          regulations do not apply, the same methodology used  
20          under section 1833(a)(3), adjusted to take into ac-  
21          count any increase in the scope of such services fur-  
22          nished by the center or clinic during fiscal year  
23          2001.

24          “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-  
25          CAL YEARS.—Subject to paragraph (4), for services

1 furnished during fiscal year 2002 or a succeeding  
 2 fiscal year, the State plan shall provide for payment  
 3 for such services in an amount (calculated on a per  
 4 visit basis) that is equal to the amount calculated for  
 5 such services under this subsection for the preceding  
 6 fiscal year—

7 “(A) increased by the percentage increase  
 8 in the MEI (as defined in section 1842(i)(3))  
 9 applicable to primary care services (as defined  
 10 in section 1842(i)(4)) for that fiscal year; and

11 “(B) adjusted to take into account any in-  
 12 crease in the scope of such services furnished by  
 13 the center or clinic during that fiscal year.

14 “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
 15 MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In  
 16 any case in which an entity first qualifies as a Fed-  
 17 erally-qualified health center or rural health clinic  
 18 after fiscal year 2000, the State plan shall provide  
 19 for payment for services described in section  
 20 1905(a)(2)(C) furnished by the center or services  
 21 described in section 1905(a)(2)(B) furnished by the  
 22 clinic in the first fiscal year in which the center or  
 23 clinic so qualifies in an amount (calculated on a per  
 24 visit basis) that is equal to 100 percent of the costs  
 25 of furnishing such services during such fiscal year in

1 accordance with the regulations and methodology re-  
2 ferred to in paragraph (2). For each fiscal year fol-  
3 lowing the fiscal year in which the entity first quali-  
4 fies as a Federally-qualified health center or rural  
5 health clinic, the State plan shall provide for the  
6 payment amount to be calculated in accordance with  
7 paragraph (3).

8 “(5) ADMINISTRATION IN THE CASE OF MAN-  
9 AGED CARE.—In the case of services furnished by a  
10 Federally-qualified health center or rural health clin-  
11 ic pursuant to a contract between the center or clinic  
12 and a managed care entity (as defined in section  
13 1932(a)(1)(B)), the State plan shall provide for pay-  
14 ment to the center or clinic (at least quarterly) by  
15 the State of a supplemental payment equal to the  
16 amount (if any) by which the amount determined  
17 under paragraphs (2), (3), and (4) of this subsection  
18 exceeds the amount of the payments provided under  
19 the contract.

20 “(6) ALTERNATIVE PAYMENT METHODOLO-  
21 GIES.—Notwithstanding any other provision of this  
22 section, the State plan may provide for payment in  
23 any fiscal year to a Federally-qualified health center  
24 for services described in section 1905(a)(2)(C) or to  
25 a rural health clinic for services described in section

1       1905(a)(2)(B) in an amount which is determined  
2       under an alternative payment methodology that—

3               “(A) is agreed to by the State and the cen-  
4       ter or clinic; and

5               “(B) results in payment to the center or  
6       clinic of an amount which is at least equal to  
7       the amount otherwise required to be paid to the  
8       center or clinic under this section.”.

9       (c) CONFORMING AMENDMENTS.—

10           (1) Section 4712 of BBA (111 Stat. 508) is  
11       amended by striking subsection (c).

12           (2) Section 1915(b) (42 U.S.C. 1396n(b)) is  
13       amended by striking “1902(a)(13)(E)” and insert-  
14       ing “1902(a)(15), 1902(aa),”.

15       (d) EFFECTIVE DATE.—The amendments made by  
16       this section take effect on October 1, 2000, and apply to  
17       services furnished on or after such date.

18   **SEC. 702. TRANSITIONAL MEDICAL ASSISTANCE.**

19       (a) MAKING PROVISION PERMANENT.—

20           (1) IN GENERAL.—Subsection (f) of section  
21       1925 (42 U.S.C. 1396r–6) is repealed.

22           (2) CONFORMING AMENDMENT.—Section  
23       1902(e)(1) (42 U.S.C. 1396a(e)(1)) is repealed.

1 (b) STATE OPTION OF INITIAL 12-MONTH ELIGI-  
 2 BILITY.—Section 1925 (42 U.S.C. 1396r–6) is  
 3 amended—

4 (1) in subsection (a), by adding at the end the  
 5 following new paragraph:

6 “(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY  
 7 PERIOD.—A State may elect to treat any reference  
 8 in this subsection to a 6-month period (or 6 months)  
 9 as a reference to a 12-month period (or 12 months).  
 10 In the case of such an election, subsection (b) shall  
 11 not apply.”; and

12 (2) in subsection (b)(1), by inserting “and sub-  
 13 section (a)(5)” after “paragraph (3)”.

14 (c) SIMPLIFICATION OPTIONS.—

15 (1) REMOVAL OF ADMINISTRATIVE REPORTING  
 16 REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTEN-  
 17 SION.—Section 1925(b) (42 U.S.C. 1396r–6(b)) is  
 18 amended—

19 (A) in paragraph (2)—

20 (i) in the heading, by striking “AND  
 21 REPORTING”;

22 (ii) by striking subparagraph (B);

23 (iii) in subparagraph (A)(i)—

1 (I) by striking “(I)” and all that  
 2 follows through “(II)” and inserting  
 3 “(i)”;

4 (II) by striking “, and (III)” and  
 5 inserting “and (ii)”;

6 (III) by redesignating such sub-  
 7 paragraph as subparagraph (A) (with  
 8 appropriate indentation); and  
 9 (iv) in subparagraph (A)(ii)—

10 (I) by striking “notify the family  
 11 of the reporting requirement under  
 12 subparagraph (B)(ii) and a statement  
 13 of” and inserting “provide the family  
 14 with notification of”; and

15 (II) by redesignating such sub-  
 16 paragraph as subparagraph (B) (with  
 17 appropriate indentation);

18 (B) in paragraph (3)(A)—

19 (i) in clause (iii)—

20 (I) in the heading, by striking  
 21 “REPORTING AND TEST”;

22 (II) by striking subclause (I);  
 23 and

1 (III) by redesignating subclauses  
 2 (II) and (III) as subclauses (I) and  
 3 (II), respectively; and  
 4 (ii) by striking the last 3 sentences;  
 5 and  
 6 (C) in paragraph (3)(B), by striking “sub-  
 7 paragraph (A)(iii)(II)” and inserting “subpara-  
 8 graph (A)(iii)(I)”.

9 (2) EXEMPTION FOR STATES COVERING NEEDY  
 10 FAMILIES UP TO 185 PERCENT OF POVERTY.—Sec-  
 11 tion 1925 (42 U.S.C. 1396r–6), as amended by sub-  
 12 section (a), is amended—

13 (A) in each of subsections (a)(1) and  
 14 (b)(1), by inserting “but subject to subsection  
 15 (f),” after “Notwithstanding any other provi-  
 16 sion of this title,”; and

17 (B) by adding at the end the following new  
 18 subsection:

19 “(f) EXEMPTION FOR STATE COVERING NEEDY  
 20 FAMILIES UP TO 185 PERCENT OF POVERTY.—At State  
 21 option, the provisions of this section shall not apply to a  
 22 State that uses the authority under section 1931(b)(2)(C)  
 23 to make medical assistance available under the State plan  
 24 under this title, at a minimum, to all individuals described  
 25 in section 1931(b)(1) in families with gross incomes (de-

1 terminated without regard to work-related child care ex-  
 2 penses of such individuals) at or below 185 percent of the  
 3 income official poverty line (as defined by the Office of  
 4 Management and Budget, and revised annually in accord-  
 5 ance with section 673(2) of the Omnibus Budget Rec-  
 6 onciliation Act of 1981) applicable to a family of the size  
 7 involved.”.

8 (3) STATE OPTION TO ELECT SHORTER PERIOD  
 9 FOR REQUIREMENT FOR RECEIPT OF MEDICAL AS-  
 10 SISTANCE AS A CONDITION OF ELIGIBILITY FOR  
 11 TRANSITIONAL MEDICAL ASSISTANCE.—Section  
 12 1925(a)(1) (42 U.S.C. 1396r-6(a)(1)) is amended  
 13 by inserting “(or such shorter period as the State  
 14 may elect)” after “3”.

15 (d) APPLICATION OF NOTICE OF ELIGIBILITY TO  
 16 ALL FAMILIES LEAVING WELFARE.—Section 1925(a) (42  
 17 U.S.C. 1396r-6(a)), as amended by subsection (b)(1), is  
 18 amended by adding at the end the following new para-  
 19 graph:

20 “(6) NOTICE OF ELIGIBILITY FOR MEDICAL AS-  
 21 SISTANCE TO ALL FAMILIES LEAVING TANF.—Each  
 22 State shall notify each family which was receiving  
 23 assistance under the State program funded under  
 24 part A of title IV and which is no longer eligible for  
 25 such assistance, of the potential eligibility of the



1 family and any individual members of such family  
 2 for medical assistance under this title or child health  
 3 assistance under title XXI. Such notice shall include  
 4 a statement that the family does not have to be re-  
 5 ceiving assistance under the State program funded  
 6 under part A of title IV in order to be eligible for  
 7 such medical assistance or child health assistance.”.

8 (e) ENROLLMENT DATA.—Section 1925 (42 U.S.C.  
 9 1396r–6), as amended by subsection (c)(2)(B), is amend-  
 10 ed by adding at the end the following new subsection:

11 “(g) ENROLLMENT DATA.—The Secretary annually  
 12 shall obtain from each State with a State plan approved  
 13 under this title enrollment data regarding—

14 “(1) the number of adults and children who—

15 “(A) receive medical assistance under this  
 16 title based on eligibility under section 1931;

17 “(B) at the time they were first deter-  
 18 mined to be eligible for such medical assistance,  
 19 also received cash assistance under the State  
 20 program funded under part A of title IV; and

21 “(C) subsequently ceased to receive assist-  
 22 ance under such State program due to in-  
 23 creased earnings or increased child support in-  
 24 come;

1           “(2) the percentage of the adults and children  
2           described in paragraph (1) who receive transitional  
3           medical assistance under this section or otherwise  
4           remain enrolled in the program under this title; and

5           “(3) the percentage of such adults and children  
6           that receive such transitional medical assistance for  
7           more than 6 months or that remain enrolled in the  
8           program under this title for more than 6 months  
9           after such adults or children ceased to receive assist-  
10          ance under the State program funded under part A  
11          of title IV.”.

12          (f) EFFECTIVE DATE.—The amendments made by  
13          this section take effect on October 1, 2000.

14   **SEC. 703. APPLICATION OF SIMPLIFIED SCHIP PROCE-**  
15                   **DURES UNDER THE MEDICAID PROGRAM.**

16          (a) COORDINATION WITH MEDICAID.—

17                  (1) IN GENERAL.—Section 1902(l) (42 U.S.C.  
18          1396a(l)) is amended—

19                          (A) in paragraph (3), by inserting “subject  
20                          to paragraph (5)”, after “Notwithstanding sub-  
21                          section (a)(17),”; and

22                          (B) by adding at the end the following new  
23                          paragraph:

24                  “(5) With respect to determining the eligibility of in-  
25          dividuals under 19 years of age for medical assistance

1 under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),  
2 (a)(10)(A)(i)(VII), (a)(10)(A)(ii)(IX), or  
3 (a)(10)(A)(ii)(XIV), notwithstanding any other provision  
4 of this title, if the State has established a State child  
5 health plan under title XXI, or expanded coverage beyond  
6 the income eligibility standards required for such individ-  
7 uals under this title under a waiver granted under section  
8 1115—

9 “(A) the State may not apply a resource stand-  
10 ard if the State does not apply such a standard  
11 under such child health plan or section 1115 waiver  
12 with respect to such individuals;

13 “(B) the State shall use the same simplified eli-  
14 gibility form (including, if applicable, permitting ap-  
15 plication other than in person) as the State uses  
16 under such State child health plan or section 1115  
17 waiver with respect to such individuals;

18 “(C) the State shall provide for initial eligibility  
19 determinations and redeterminations of eligibility  
20 using the same verification policies, forms, and fre-  
21 quency as the State uses for such purposes under  
22 such State child health plan or section 1115 waiver  
23 with respect to such individuals; and

24 “(D) the State shall not require a face-to-face  
25 interview for purposes of initial eligibility determina-

1        tions and redeterminations unless the State required  
 2        such an interview for such purposes under such child  
 3        health plan or section 1115 waiver with respect to  
 4        such individuals.”.

5            (2) EFFECTIVE DATE.—The amendments made  
 6        by paragraph (1) take effect on October 1, 2000,  
 7        and apply to eligibility determinations and redeter-  
 8        minations made on or after such date.

9            (b) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR  
 10        TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN  
 11        LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

12            (1) LOSS OF MEDICAID ELIGIBILITY.—Section  
 13        1902(a) of the Social Security Act (42 U.S.C.  
 14        1396a(a)) is amended—

15            (A) by striking the period at the end of  
 16        paragraph (65) and inserting “; and”, and

17            (B) by inserting after paragraph (65) the  
 18        following new paragraph:

19            “(66) provide, by not later than the first day of  
 20        the first month that begins more than 1 year after  
 21        the date of the enactment of this paragraph and in  
 22        the case of a State with a State child health plan  
 23        under title XXI, that before medical assistance to a  
 24        child (or a parent of a child) is discontinued under  
 25        this title, a determination of whether the child (or

parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State.”.

(2) LOSS OF TITLE XXI ELIGIBILITY.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following new subparagraph:

“(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application and without being asked to provide any information that is already available to the State;”.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who

1       lose eligibility under the medicaid program under  
 2       title XIX, or under a State child health insurance  
 3       plan under title XXI, respectively, of the Social Se-  
 4       curity Act (42 U.S.C. 1396 et seq.; 1397aa et seq.)  
 5       on or after the date that is 60 days after the date  
 6       of the enactment of this Act.

7   **SEC. 704. PRESUMPTIVE ELIGIBILITY.**

8       (a) ADDITIONAL ENTITIES QUALIFIED TO DETER-  
 9       MINE PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME  
 10      CHILDREN.—

11           (1) MEDICAID.—Section 1920A(b)(3)(A)(i) (42  
 12      U.S.C. 1396r-1a(b)(3)(A)(i)) is amended—

13                   (A) by striking “or (II)” and inserting  
 14                   “, (II)”; and

15                   (B) by inserting “eligibility of a child for  
 16                   medical assistance under the State plan under  
 17                   this title, or eligibility of a child for child health  
 18                   assistance under the program funded under  
 19                   title XXI, (III) is an elementary school or sec-  
 20                   ondary school, as such terms are defined in sec-  
 21                   tion 14101 of the Elementary and Secondary  
 22                   Education Act of 1965 (20 U.S.C. 8801), an el-  
 23                   ementary or secondary school operated or sup-  
 24                   ported by the Bureau of Indian Affairs, a State

1 child support enforcement agency, a child care  
 2 resource and referral agency, an organization  
 3 that is providing emergency food and shelter  
 4 under a grant under the Stewart B. McKinney  
 5 Homeless Assistance Act, or a State office or  
 6 entity involved in enrollment in the program  
 7 under this title, under part A of title IV, under  
 8 title XXI, or that determines eligibility for any  
 9 assistance or benefits provided under any pro-  
 10 gram of public or assisted housing that receives  
 11 Federal funds, including the program under  
 12 section 8 or any other section of the United  
 13 States Housing Act of 1937 (42 U.S.C. 1437 et  
 14 seq.), or (IV) any other entity the State so  
 15 deems, as approved by the Secretary” before  
 16 the semicolon.

17 (2) APPLICATION UNDER SCHIP.—

18 (A) IN GENERAL.—Section 2107(e)(1) (42  
 19 U.S.C. 1397gg(e)(1)) is amended by adding at  
 20 the end the following new subparagraph:

21 “(D) Section 1920A (relating to presump-  
 22 tive eligibility).”.

23 (B) EXCEPTION FROM LIMITATION ON AD-  
 24 MINISTRATIVE EXPENSES.—Section 2105(c)(2)

1 (42 U.S.C. 1397ee(c)(2)) is amended by adding  
 2 at the end the following new subparagraph:

3 “(C) EXCEPTION FOR PRESUMPTIVE ELI-  
 4 GIBILITY EXPENDITURES.—The limitation  
 5 under subparagraph (A) on expenditures shall  
 6 not apply to expenditures attributable to the  
 7 application of section 1920A (pursuant to sec-  
 8 tion 2107(e)(1)(D)), regardless of whether the  
 9 child is determined to be ineligible for the pro-  
 10 gram under this title or title XIX.”.

11 (3) TECHNICAL AMENDMENTS.—Section 1920A  
 12 (42 U.S.C. 1396r-1a) is amended—

13 (A) in subsection (b)(3)(A)(ii), by striking  
 14 “paragraph (1)(A)” and inserting “paragraph  
 15 (2)(A)”; and

16 (B) in subsection (c)(2), in the matter pre-  
 17 ceding subparagraph (A), by striking “sub-  
 18 section (b)(1)(A)” and inserting “subsection  
 19 (b)(2)(A)”.

20 (b) ELIMINATION OF SCHIP FUNDING OFFSET FOR  
 21 EXERCISE OF PRESUMPTIVE ELIGIBILITY OPTION.—

22 (1) IN GENERAL.—Section 2104(d) (42 U.S.C.  
 23 1397dd(d)) is amended by striking “the sum of—”  
 24 and all that follows through “(2)” and conforming  
 25 the margins of all that remains accordingly.



1           (2) EFFECTIVE DATE.—The amendment made  
 2       by paragraph (1) takes effect October 1, 2000, and  
 3       applies to allotments under title XXI of the Social  
 4       Security Act (42 U.S.C. 1397aa et seq.) for fiscal  
 5       year 2001 and each succeeding fiscal year there-  
 6       after.

7   **SEC. 705. IMPROVEMENTS TO THE MATERNAL AND CHILD**  
 8                           **HEALTH SERVICES BLOCK GRANT.**

9       (a) INCREASE IN AUTHORIZATION OF APPROPRIA-  
 10      TIONS.—Section 501(a) (42 U.S.C. 701(a)) is amended in  
 11      the matter preceding paragraph (1) by striking  
 12      “\$705,000,000 for fiscal year 1994” and inserting  
 13      “\$1,000,000,000 for fiscal year 2001”.

14      (b) COORDINATION WITH MEDICAID AND SCHIP.—

15           (1) SCHIP.—Section 505(a)(5)(F) (42 U.S.C.  
 16      705(a)(5)(F)) is amended—

17                   (A) in clause (ii), by inserting “and in the  
 18                   coordination of the administration of the State  
 19                   program under title XXI with the care and  
 20                   services available under this title, as required  
 21                   under subsections (b)(3)(G) and (c)(2) of sec-  
 22                   tion 2102” before the comma; and

23                   (B) in clause (iv), by striking “and infants  
 24                   who are eligible for medical assistance under  
 25                   subparagraph (A) or (B) of section 1902(l)(1)”

1 and inserting “, infants, and children who are  
 2 eligible for medical assistance under section  
 3 1902(l)(1), and children who are eligible for  
 4 child health assistance under the State program  
 5 under title XXI”.

6 (2) CONFORMING AMENDMENTS TO SCHIP.—  
 7 Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)), as  
 8 amended by section 703(b)(2), is amended—

9 (A) by striking “and” at the end of sub-  
 10 paragraph (E);

11 (B) by striking the period at the end of  
 12 subparagraph (F) and inserting “; and”; and

13 (C) by adding at the end the following new  
 14 subparagraph:

15 “(G) that operations and activities under  
 16 this title are developed and implemented in con-  
 17 sultation and coordination with the program op-  
 18 erated by the State under title V with respect  
 19 to outreach and enrollment, benefits and serv-  
 20 ices, service delivery standards, public health  
 21 and social service agency relationships, and  
 22 quality assurance and data reporting.”.

23 (c) EFFECTIVE DATE.—The amendments made by  
 24 this section take effect on October 1, 2000.

1 **SEC. 706. IMPROVING ACCESS TO MEDICARE COST-SHAR-**  
 2 **ING ASSISTANCE FOR LOW-INCOME BENE-**  
 3 **FICIARIES.**

4 (a) INCREASE IN SLMB ELIGIBILITY.—

5 (1) IN GENERAL.—Section 1902(a)(10)(E) (42  
 6 U.S.C. 1396a(a)(10)(E)) is amended—

7 (A) in clause (iii), by striking “and 120  
 8 percent in 1995” and inserting “, 120 percent  
 9 in 1995 through 2000, and 135 percent in  
 10 2001”; and

11 (B) in clause (iv), by striking “2002)—”  
 12 and all that follows through “(II) for” and in-  
 13 serting “2002) for”.

14 (2) CONFORMING AMENDMENT.—Section  
 15 1933(c)(2)(A) (42 U.S.C. 1396u–3(c)(2)(A)) is  
 16 amended by striking “sum of—” and all that follows  
 17 through “(ii) the”.”.

18 (3) EFFECTIVE DATE.—The amendments made  
 19 by this subsection take effect on January 1, 2001,  
 20 and with respect to the amendment made by para-  
 21 graph (2), applies to allocations determined under  
 22 section 1933(c) of the Social Security Act (42  
 23 U.S.C. 1396u–3(c)) for the last 3 quarters of fiscal  
 24 year 2001 and all of fiscal year 2002.

25 (b) INDEX OF ASSETS TEST TO INFLATION.—Section  
 26 1905(p)(1)(C) (42 U.S.C. 1396d(p)(1)(C)) is amended by

1 inserting “, increased (beginning with 2001 and each year  
 2 thereafter) by the percentage increase (if any) in the Con-  
 3 sumer Price Index for All Urban Consumers (United  
 4 States city average)” before the period.

5 (c) INCREASED EFFORT TO PROVIDE MEDICARE  
 6 BENEFICIARIES WITH MEDICARE COST-SHARING UNDER  
 7 THE MEDICAID PROGRAM.—

8 (1) IN GENERAL.—Section 1902(a) (42 U.S.C.  
 9 1396a(a)), as amended by section 703(b)(1)(A), is  
 10 amended—

11 (A) in paragraph (65), by striking “and”  
 12 at the end;

13 (B) in paragraph (66), by striking the pe-  
 14 riod and inserting “; and”; and

15 (C) by inserting after paragraph (66) the  
 16 following new paragraph:

17 “(67) provide for the determination of eligibility  
 18 for medicare cost-sharing (as defined in section  
 19 1905(p)(3)) for individuals described in paragraph  
 20 (10)(E) and, if eligible for such medicare cost-shar-  
 21 ing, for the enrollment of such individuals at any  
 22 hospital, clinic, or similar entity at which State or  
 23 local agency personnel are stationed for the purpose  
 24 of determining the eligibility of individuals for med-  
 25 ical assistance under the State plan or providing

1 outreach services to eligible or potentially eligible in-  
 2 dividuals.”.

3 (2) EFFECTIVE DATE.—The amendments made  
 4 by this paragraph shall take effect on the date of en-  
 5 actment of this Act.

6 (d) PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-IN-  
 7 COME INDIVIDUALS FOR MEDICARE COST-SHARING  
 8 UNDER THE QMB OR SLMB PROGRAM.—Title XIX (42  
 9 U.S.C. 1396 et seq.) is amended by inserting after section  
 10 1920A the following new section:

11 “PRESUMPTIVE ELIGIBILITY OF CERTAIN LOW-INCOME  
 12 INDIVIDUALS

13 “SEC. 1920B. (a) A State plan approved under sec-  
 14 tion 1902 shall provide for making medical assistance with  
 15 respect to medicare cost-sharing covered under the State  
 16 plan available to a low-income individual on the date the  
 17 low-income individual becomes entitled to benefits under  
 18 part A of title XVIII during a presumptive eligibility pe-  
 19 riod.

20 “(b) For purposes of this section:

21 “(1) The term ‘low-income individual’ means an  
 22 individual who at the age of 65 years is described—

23 “(A) in section 1902(a)(10)(E)(i), or

24 “(B) in section 1902(a)(10)(E)(iii).

25 “(2) The term ‘medicare cost-sharing’—

1           “(A) with respect to an individual de-  
 2           scribed in paragraph (1)(A), has the meaning  
 3           given such term in section 1905(p)(3); and

4           “(B) with respect to an individual de-  
 5           scribed in paragraph (1)(B), has the meaning  
 6           given such term in section 1905(p)(3)(A).

7           “(3) The term ‘presumptive eligibility period’  
 8           means, with respect to a low-income individual, the  
 9           period that—

10           “(A) begins with the date on which a  
 11           qualified entity determines, on the basis of pre-  
 12           liminary information, that the income and re-  
 13           sources of the individual do not exceed the ap-  
 14           plicable income and resource level of eligibility  
 15           under the State plan, and

16           “(B) ends with (and includes) the earlier  
 17           of—

18           “(i) the day on which a determination  
 19           is made with respect to the eligibility of  
 20           the low-income individual for medical as-  
 21           sistance for medical cost-sharing under the  
 22           State plan, or

23           “(ii) in the case of a low-income indi-  
 24           vidual on whose behalf an application is  
 25           not filed by the last day of the month fol-

1           lowing the month during which the entity  
2           makes the determination referred to in  
3           subparagraph (A), such last day.

4           “(4)(A) Subject to subparagraph (B), the term  
5           ‘qualified entity’ means any of the following:

6                   “(i) Qualified individuals within the Social  
7           Security Administration.

8                   “(ii) An entity determined by the State  
9           agency to be capable of making determinations  
10          of the type described in paragraph (3).

11          “(B) The Secretary may issue regulations fur-  
12          ther limiting those entities that may become quali-  
13          fied entities in order to prevent fraud and abuse and  
14          for other reasons.

15          “(c)(1) The State agency, after consultation with the  
16          Secretary, shall provide qualified entities with—

17                  “(A) such forms as are necessary for an appli-  
18          cation to be made on behalf of a low-income indi-  
19          vidual for medical assistance for medical cost-shar-  
20          ing under the State plan, and

21                  “(B) information on how to assist low-income  
22          individuals and other persons in completing and fil-  
23          ing such forms.

24          “(2) A qualified entity that determines under sub-  
25          section (b)(2)(A) that a low-income individual is presump-

1 tively eligible for medical assistance for medical cost-shar-  
2 ing under a State plan shall—

3 “(A) notify the State agency of the determina-  
4 tion within 5 working days after the date on which  
5 the determination is made, and

6 “(B) inform the low-income individual at the  
7 time the determination is made that an application  
8 for medical assistance for medical cost-sharing under  
9 the State plan is required to be made by not later  
10 than the last day of the month following the month  
11 during which the determination is made.

12 “(3) In the case of a low-income individual who is  
13 determined by a qualified entity to be presumptively eligi-  
14 ble for medical assistance for medical cost-sharing under  
15 a State plan, the low-income individual shall make applica-  
16 tion for medical assistance for medical cost-sharing under  
17 such plan by not later than the last day of the month fol-  
18 lowing the month during which the determination is made.

19 “(d) Notwithstanding any other provision of this title,  
20 medical assistance for medicare cost-sharing that—

21 “(1) is furnished to a low-income individual  
22 during a presumptive eligibility period under the  
23 State plan; and

24 “(2) is included in the services covered by a  
25 State plan;



1 shall be treated as medical assistance provided by such  
 2 plan for purposes of section 1903.”.

3 **SEC. 707. BREAST AND CERVICAL CANCER PREVENTION**  
 4 **AND TREATMENT.**

5 (a) COVERAGE AS OPTIONAL CATEGORICALLY  
 6 NEEDY GROUP.—

7 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)  
 8 (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

9 (A) in subclause (XVI), by striking “or” at  
 10 the end;

11 (B) in subclause (XVII), by adding “or” at  
 12 the end; and

13 (C) by adding at the end the following:

14 “(XVIII) who are described in  
 15 subsection (aa) (relating to certain  
 16 breast or cervical cancer patients);”.

17 (2) GROUP DESCRIBED.—Section 1902 (42  
 18 U.S.C. 1396a) is amended by adding at the end the  
 19 following:

20 “(aa) Individuals described in this subsection are in-  
 21 dividuals who—

22 “(1) are not described in subsection  
 23 (a)(10)(A)(i);

24 “(2) have not attained age 65;

1           “(3) have been screened for breast and cervical  
 2           cancer under the Centers for Disease Control and  
 3           Prevention breast and cervical cancer early detection  
 4           program established under title XV of the Public  
 5           Health Service Act (42 U.S.C. 300k et seq.) in ac-  
 6           cordance with the requirements of section 1504 of  
 7           that Act (42 U.S.C. 300n) and need treatment for  
 8           breast or cervical cancer; and

9           “(4) are not otherwise covered under creditable  
 10          coverage, as defined in section 2701(c) of the Public  
 11          Health Service Act (42 U.S.C. 300gg(c)).”.

12           (3)   LIMITATION   ON   BENEFITS.—Section  
 13          1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended  
 14          in the matter following subparagraph (G)—

15                   (A) by striking “and (XIII)” and inserting  
 16                   “(XIII)”; and

17                   (B) by inserting “, and (XIV) the medical  
 18                   assistance made available to an individual de-  
 19                   scribed in subsection (aa) who is eligible for  
 20                   medical assistance only because of subpara-  
 21                   graph (A)(10)(ii)(XVIII) shall be limited to  
 22                   medical assistance provided during the period in  
 23                   which such an individual requires treatment for  
 24                   breast or cervical cancer” before the semicolon.

1           (4) CONFORMING AMENDMENTS.—Section  
2       1905(a) (42 U.S.C. 1396d(a)) is amended in the  
3       matter preceding paragraph (1)—

4                   (A) in clause (xi), by striking “or” at the  
5       end;

6                   (B) in clause (xii), by adding “or” at the  
7       end; and

8                   (C) by inserting after clause (xii) the fol-  
9       lowing:

10           “(xiii) individuals described in section  
11       1902(aa),”.

12       (b) PRESUMPTIVE ELIGIBILITY.—

13           (1) IN GENERAL.—Title XIX (42 U.S.C. 1396  
14       et seq.) is amended by inserting after section 1920A  
15       the following:

16       “PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR  
17                   CERVICAL CANCER PATIENTS

18       “SEC. 1920B. (a) STATE OPTION.—A State plan ap-  
19       proved under section 1902 may provide for making med-  
20       ical assistance available to an individual described in sec-  
21       tion 1902(aa) (relating to certain breast or cervical cancer  
22       patients) during a presumptive eligibility period.

23       “(b) DEFINITIONS.—For purposes of this section:

24           “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The  
25       term ‘presumptive eligibility period’ means, with re-

1       spect to an individual described in subsection (a),  
 2       the period that—

3               “(A) begins with the date on which a  
 4               qualified entity determines, on the basis of pre-  
 5               liminary information, that the individual is de-  
 6               scribed in section 1902(aa); and

7               “(B) ends with (and includes) the earlier  
 8               of—

9                       “(i) the day on which a determination  
 10                      is made with respect to the eligibility of  
 11                      such individual for services under the State  
 12                      plan; or

13                     “(ii) in the case of such an individual  
 14                     who does not file an application by the last  
 15                     day of the month following the month dur-  
 16                     ing which the entity makes the determina-  
 17                     tion referred to in subparagraph (A), such  
 18                     last day.

19       “(2) QUALIFIED ENTITY.—

20               “(A) IN GENERAL.—Subject to subpara-  
 21               graph (B), the term ‘qualified entity’ means  
 22               any entity that—

23                     “(i) is eligible for payments under a  
 24                     State plan approved under this title; and

1                   “(ii) is determined by the State agen-  
 2                   cy to be capable of making determinations  
 3                   of the type described in paragraph (1)(A).

4                   “(B) REGULATIONS.—The Secretary may  
 5                   issue regulations further limiting those entities  
 6                   that may become qualified entities in order to  
 7                   prevent fraud and abuse and for other reasons.

8                   “(C) RULE OF CONSTRUCTION.—Nothing  
 9                   in this paragraph shall be construed as pre-  
 10                  venting a State from limiting the classes of en-  
 11                  tities that may become qualified entities, con-  
 12                  sistent with any limitations imposed under sub-  
 13                  paragraph (B).

14               “(c) ADMINISTRATION.—

15               “(1) IN GENERAL.—The State agency shall pro-  
 16               vide qualified entities with—

17                   “(A) such forms as are necessary for an  
 18                   application to be made by an individual de-  
 19                   scribed in subsection (a) for medical assistance  
 20                   under the State plan; and

21                   “(B) information on how to assist such in-  
 22                   dividuals in completing and filing such forms.

23               “(2) NOTIFICATION REQUIREMENTS.—A quali-  
 24               fied entity that determines under subsection  
 25               (b)(1)(A) that an individual described in subsection

1       (a) is presumptively eligible for medical assistance  
2       under a State plan shall—

3               “(A) notify the State agency of the deter-  
4               mination within 5 working days after the date  
5               on which the determination is made; and

6               “(B) inform such individual at the time  
7               the determination is made that an application  
8               for medical assistance under the State plan is  
9               required to be made by not later than the last  
10              day of the month following the month during  
11              which the determination is made.

12             “(3) APPLICATION FOR MEDICAL ASSIST-  
13             ANCE.—In the case of an individual described in  
14             subsection (a) who is determined by a qualified enti-  
15             ty to be presumptively eligible for medical assistance  
16             under a State plan, the individual shall apply for  
17             medical assistance under such plan by not later than  
18             the last day of the month following the month dur-  
19             ing which the determination is made.

20             “(d) PAYMENT.—Notwithstanding any other provi-  
21             sion of this title, medical assistance that—

22               “(1) is furnished to an individual described in  
23               subsection (a)—

1           “(A) during a presumptive eligibility pe-  
2           riod; and

3           “(B) by a entity that is eligible for pay-  
4           ments under the State plan; and

5           “(2) is included in the care and services covered  
6           by the State plan,  
7           shall be treated as medical assistance provided by such  
8           plan for purposes of clause (4) of the first sentence of  
9           section 1905(b).”.

10           (2) CONFORMING AMENDMENTS.—

11           (A) Section 1902(a)(47) (42 U.S.C.  
12           1396a(a)(47)) is amended by inserting before  
13           the semicolon at the end the following: “and  
14           provide for making medical assistance available  
15           to individuals described in subsection (a) of sec-  
16           tion 1920B during a presumptive eligibility pe-  
17           riod in accordance with such section”.

18           (B) Section 1903(u)(1)(D)(v) (42 U.S.C.  
19           1396b(u)(1)(D)(v)) is amended—

20                   (i) by striking “or for” and inserting  
21                   “, for”; and

22                   (ii) by inserting before the period the  
23                   following: “, or for medical assistance pro-  
24                   vided to an individual described in sub-  
25                   section (a) of section 1920B during a pre-

1                   sumptive eligibility period under such sec-  
2                   tion”.

3           (c) ENHANCED MATCH.—The first sentence of sec-  
4   tion 1905(b) (42 U.S.C. 1396d(b)) is amended—

5                   (1) by striking “and” before “(3)”; and

6                   (2) by inserting before the period at the end the  
7   following: “, and (4) the Federal medical assistance  
8   percentage shall be equal to the enhanced FMAP de-  
9   scribed in section 2105(b) with respect to medical  
10   assistance provided to individuals who are eligible  
11   for such assistance only on the basis of section  
12   1902(a)(10)(A)(ii)(XVIII)”.

13          (d) EFFECTIVE DATE.—The amendments made by  
14   this section apply to medical assistance for items and serv-  
15   ices furnished on or after October 1, 2000, without regard  
16   to whether final regulations to carry out such amendments  
17   have been promulgated by such date.

## 18   **TITLE VIII—OTHER PROVISIONS**

### 19   **SEC. 801. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA** 20                   **RELIEF FUND.**

21          Section 101(e) of the Ricky Ray Hemophilia Relief  
22   Fund Act of 1998 (42 U.S.C. 300c–22 note) is amended  
23   by adding at the end the following: “There is appropriated  
24   to the Fund \$475,000,000 for fiscal year 2001, to remain  
25   available until expended.”.



1 **SEC. 802. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-**  
2 **ABETES PROGRAMS FOR CHILDREN WITH**  
3 **TYPE I DIABETES AND INDIANS.**

4 (a) SPECIAL DIABETES PROGRAMS FOR CHILDREN  
5 WITH TYPE I DIABETES.—Section 330B(b) of the Public  
6 Health Service Act (42 U.S.C. 254c–2(b)) is amended—

7 (1) by striking “Notwithstanding” and insert-  
8 ing the following:

9 “(1) TRANSFERRED FUNDS.—Notwith-  
10 standing”; and

11 (2) by adding at the end the following:

12 “(2) APPROPRIATIONS.—For the purpose of  
13 making grants under this section, there are appro-  
14 priated, out of any money in the Treasury not other-  
15 wise appropriated—

16 “(A) \$70,000,000 for each of fiscal years  
17 2001 and 2002 (which shall be combined with  
18 amounts transferred under paragraph (1) for  
19 each such fiscal years); and

20 “(B) \$100,000,000 for each of fiscal years  
21 2003 through 2005.”.

22 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
23 Section 330C(c) of the Public Health Service Act (42  
24 U.S.C. 254c–3(c)) is amended—

25 (1) by striking “Notwithstanding” and insert-  
26 ing the following:

1           “(1)       TRANSFERRED       FUNDS.—Notwith-  
2       standing”;

3           (2) by adding at the end the following:

4           “(2)   APPROPRIATIONS.—For the purpose of  
5       making grants under this section, there are appro-  
6       priated, out of any money in the Treasury not other-  
7       wise appropriated—

8                   “(A) \$70,000,000 for each of fiscal years  
9       2001 and 2002 (which shall be combined with  
10      amounts transferred under paragraph (1) for  
11      each such fiscal years); and

12                   “(B) \$100,000,000 for each of fiscal years  
13      2003 through 2005.”.

14 **SEC. 803. DEMONSTRATION GRANTS TO IMPROVE OUT-**  
15 **REACH, ENROLLMENT, AND COORDINATION**  
16 **OF PROGRAMS AND SERVICES TO HOMELESS**  
17 **INDIVIDUALS AND FAMILIES.**

18       (a) **AUTHORITY.**—The Secretary of Health and  
19 Human Services may award demonstration grants to not  
20 more than 7 States (or other qualified entities) to conduct  
21 innovative programs that are designed to improve out-  
22 reach to homeless individuals and families under the pro-  
23 grams described in subsection (b) with respect to enroll-  
24 ment of such individuals and families under such pro-

1 grams and the provision of services (and coordinating the  
2 provision of such services) under such programs.

3 (b) PROGRAMS FOR HOMELESS DESCRIBED.—The  
4 programs described in this subsection are as follows:

5 (1) MEDICAID.—The program under title XIX  
6 of the Social Security Act (42 U.S.C. 1396 et seq.).

7 (2) SCHIP.—The program under title XXI of  
8 such Act (42 U.S.C. 1397aa et seq.).

9 (3) TANF.—The program under part A of title  
10 IV of such Act (42 U.S.C. 601 et seq.).

11 (4) MATERNAL AND CHILD HEALTH BLOCK  
12 GRANTS.—The program under title V of the Social  
13 Security Act (42 U.S.C. 701 et seq.).

14 (5) MENTAL HEALTH AND SUBSTANCE ABUSE  
15 BLOCK GRANTS.—The program under part B of title  
16 XIX of the Public Health Service Act (42 U.S.C.  
17 300x–1 et seq.).

18 (6) HIV/AIDS CARE GRANTS.—The program  
19 under part B of title XXVI of the Public Health  
20 Service Act (42 U.S.C. 300ff–21 et seq.).

21 (7) FOOD STAMP PROGRAM.—The program  
22 under the Food Stamp Act of 1977 (7 U.S.C. 2011  
23 et seq.).

1           (8) WORKFORCE INVESTMENT ACT.—The pro-  
 2           gram under the Workforce Investment Act of 1999  
 3           (29 U.S.C. 2801 et seq.).

4           (9) WELFARE-TO-WORK.—The welfare-to-work  
 5           program under section 403(a)(5) of the Social Secu-  
 6           rity Act (42 U.S.C. 603(a)(5)).

7           (10) OTHER PROGRAMS.—Other public and pri-  
 8           vate benefit programs that serve low-income individ-  
 9           uals.

10          (c) APPROPRIATIONS.—For the purposes of carrying  
 11          out this section, there are appropriated, out of any funds  
 12          in the Treasury not otherwise appropriated, \$10,000,000,  
 13          to remain available until expended.

14      **SEC. 804. PROTECTION OF AN HMO ENROLLEE TO RECEIVE**  
 15                              **CONTINUING CARE AT A FACILITY SELECTED**  
 16                              **BY THE ENROLLEE.**

17          (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT  
 18          INCOME SECURITY ACT OF 1974.—

19           (1) IN GENERAL.—Subpart B of part 7 of sub-  
 20           title B of title I of the Employee Retirement Income  
 21           Security Act of 1974 (29 U.S.C. 1185 et seq.) is  
 22           amended by adding at the end the following new sec-  
 23           tion:

1 **“SEC. 714. ENSURING CHOICE FOR CONTINUING CARE.**

2       “(a) IN GENERAL.—With respect to health insurance  
3 coverage provided to participants or beneficiaries through  
4 a managed care organization under a group health plan,  
5 or through a health insurance issuer providing health in-  
6 surance coverage in connection with a group health plan,  
7 such plan or issuer may not deny coverage for services  
8 provided to such participant or beneficiary by a continuing  
9 care retirement community, skilled nursing facility, or  
10 other qualified facility in which the participant or bene-  
11 ficiary resided prior to a hospitalization, regardless of  
12 whether such organization is under contract with such  
13 community or facility if the requirements described in sub-  
14 section (b) are met.

15       “(b) REQUIREMENTS.—The requirements of this sub-  
16 section are that—

17               “(1) the service involved is a service for which  
18 the managed care organization involved would be re-  
19 quired to provide or pay for under its contract with  
20 the participant or beneficiary if the continuing care  
21 retirement community, skilled nursing facility, or  
22 other qualified facility were under contract with the  
23 organization;

24               “(2) the participant or beneficiary involved—

25                       “(A) resided in the continuing care retire-  
26 ment community, skilled nursing facility, or

1 other qualified facility prior to being hospital-  
2 ized;

3 “(B) had a contractual or other right to  
4 return to the facility after hospitalization; and

5 “(C) elects to return to the facility after  
6 hospitalization, whether or not the residence of  
7 the participant or beneficiary after returning  
8 from the hospital is the same part of the facility  
9 in which the beneficiary resided prior to hos-  
10 pitalization;

11 “(3) the continuing care retirement community,  
12 skilled nursing facility, or other qualified facility has  
13 the capacity to provide the services the participant  
14 or beneficiary needs; and

15 “(4) the continuing care retirement community,  
16 skilled nursing facility, or other qualified facility is  
17 willing to accept substantially similar payment under  
18 the same terms and conditions that apply to simi-  
19 larly situated health care facility providers under  
20 contract with the organization involved.

21 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A  
22 group health plan or health insurance issuer to which this  
23 section applies may not deny payment for a skilled nursing  
24 service provided to a participant or beneficiary by a con-  
25 tinuing care retirement community, skilled nursing facil-

1 ity, or other qualified facility in which the participant or  
 2 beneficiary resides, without a preceding hospital stay, re-  
 3 gardless of whether the organization is under contract  
 4 with such community or facility, if—

5           “(1) the plan or issuer has determined that the  
 6 service is necessary to prevent the hospitalization of  
 7 the participant or beneficiary; and

8           “(2) the service to prevent hospitalization is  
 9 provided as an additional benefit as described in sec-  
 10 tion 417.594 of title 42, Code of Federal Regula-  
 11 tions, and would otherwise be covered as provided  
 12 for in subsection (b)(1).

13       “(d) RIGHTS OF SPOUSES.—A group health plan or  
 14 health insurance issuer to which this section applies shall  
 15 not deny payment for services provided by a skilled nurs-  
 16 ing facility for the care of a participant or beneficiary, re-  
 17 gardless of whether the plan or issuer is under contract  
 18 with such facility, if the spouse of the participant or bene-  
 19 ficiary is already a resident of such facility and the re-  
 20 quirements described in subsection (b) are met.

21       “(e) EXCEPTIONS.—Subsection (a) shall not apply—

22           “(1) where the attending acute care provider  
 23 and the participant or beneficiary (or a designated  
 24 representative of the participant or beneficiary where  
 25 the participant or beneficiary is physically or men-

1       tally incapable of making an election under this  
2       paragraph) do not elect to pursue a course of treat-  
3       ment necessitating continuing care; or

4               “(2) unless the community or facility involved—

5                       “(A) meets all applicable licensing and cer-  
6                       tification requirements of the State in which it  
7                       is located; and

8                       “(B) agrees to reimbursement for the care  
9                       of the participant or beneficiary at a rate simi-  
10                      lar to the rate negotiated by the managed care  
11                      organization with similar providers of care for  
12                      similar services.

13       “(f) PROHIBITIONS.—A group health plan and a  
14       health insurance issuer providing health insurance cov-  
15       erage in connection with a group health plan may not—

16               “(1) deny to an individual eligibility, or contin-  
17               ued eligibility, to enroll or to renew coverage with a  
18               managed care organization under the plan, solely for  
19               the purpose of avoiding the requirements of this sec-  
20               tion;

21               “(2) provide monetary payments or rebates to  
22               enrollees to encourage such enrollees to accept less  
23               than the minimum protections available under this  
24               section;



1           “(3) penalize or otherwise reduce or limit the  
2 reimbursement of an attending physician because  
3 such physician provided care to a participant or ben-  
4 eficiary in accordance with this section; or

5           “(4) provide incentives (monetary or otherwise)  
6 to an attending physician to induce such physician  
7 to provide care to a participant or beneficiary in a  
8 manner inconsistent with this section.

9           “(g) RULES OF CONSTRUCTION.—

10           “(1) HMO NOT OFFERING BENEFITS.—This  
11 section shall not apply with respect to any managed  
12 care organization under a group health plan, or  
13 through a health insurance issuer providing health  
14 insurance coverage in connection with a group health  
15 plan, that does not provide benefits for stays in a  
16 continuing care retirement community, skilled nurs-  
17 ing facility, or other qualified facility.

18           “(2) COST-SHARING.—Nothing in this section  
19 shall be construed as preventing a managed care or-  
20 ganization under a group health plan, or through a  
21 health insurance issuer providing health insurance  
22 coverage in connection with a group health plan,  
23 from imposing deductibles, coinsurance, or other  
24 cost-sharing in relation to benefits for care in a con-  
25 tinuing care facility.

1       “(h) PREEMPTION; EXCEPTION FOR HEALTH INSUR-  
2 ANCE COVERAGE IN CERTAIN STATES.—

3               “(1) IN GENERAL.—The requirements of this  
4 section shall not apply with respect to health insur-  
5 ance coverage to the extent that a State law (as de-  
6 fined in section 2723(d)(1) of the Public Health  
7 Service Act) applies to such coverage and is de-  
8 scribed in any of the following subparagraphs:

9               “(A) Such State law requires such cov-  
10 erage to provide for referral to a continuing  
11 care retirement community, skilled nursing fa-  
12 cility, or other qualified facility in a manner  
13 that is more protective of participants or bene-  
14 ficiaries than the provisions of this section.

15               “(B) Such State law expands the range of  
16 services or facilities covered under this section  
17 and is otherwise more protective of the rights of  
18 participants or beneficiaries than the provisions  
19 of this section.

20               “(2) CONSTRUCTION.—Section 731(a)(1) shall  
21 not be construed to provide that any requirement of  
22 this section applies with respect to health insurance  
23 coverage, to the extent that a State law described in  
24 paragraph (1) applies to such coverage.

1       “(i) PENALTIES.—A participant or beneficiary may  
2 enforce the provisions of this section in an appropriate  
3 Federal district court. An action for injunctive relief or  
4 damages may be commenced on behalf of the participant  
5 or beneficiary by the participant’s or beneficiary’s legal  
6 representative. The court may award reasonable attorneys’  
7 fees to the prevailing party. If a beneficiary dies before  
8 conclusion of an action under this section, the action may  
9 be maintained by a representative of the participant’s or  
10 beneficiary’s estate.

11       “(j) DEFINITIONS.—In this section:

12               “(1) ATTENDING ACUTE CARE PROVIDER.—The  
13 term ‘attending acute care provider’ means anyone  
14 licensed or certified under State law to provide  
15 health care services who is operating within the  
16 scope of such license and who is primarily respon-  
17 sible for the care of the enrollee.

18               “(2) CONTINUING CARE RETIREMENT COMMU-  
19 NITY.—The term ‘continuing care retirement com-  
20 munity’ means an organization that provides or ar-  
21 ranges for the provision of housing and health-re-  
22 lated services to an older person under an agreement  
23 effective for the life of the person or for a specified  
24 period greater than 1 year.

1           “(3) MANAGED CARE ORGANIZATION.—The  
2           term ‘managed care organization’ means an organi-  
3           zation that provides comprehensive health services to  
4           participants or beneficiaries, directly or under con-  
5           tract or other agreement, on a prepayment basis to  
6           such individuals. For purposes of this section, the  
7           following shall be considered as managed care orga-  
8           nizations:

9                   “(A) A Medicare+Choice plan authorized  
10                  under section 1851(a) of the Social Security  
11                  Act (42 U.S.C. 1395w–21(a)).

12                  “(B) Any other entity that manages the  
13                  cost, utilization, and delivery of health care  
14                  through the use of predetermined periodic pay-  
15                  ments to health care providers employed by or  
16                  under contract or other agreement, directly or  
17                  indirectly, with the entity.

18           “(4) OTHER QUALIFIED FACILITY.—The term  
19           ‘other qualified facility’ means any facility that can  
20           provide the services required by the participant or  
21           beneficiary consistent with State and Federal law.

22           “(5) SKILLED NURSING FACILITY.—The term  
23           ‘skilled nursing facility’ means a facility that meets  
24           the requirements of section 1819 of the Social Secu-  
25           rity Act (42 U.S.C. 1395i–3).”.

1           (2) CLERICAL AMENDMENT.—The table of con-  
 2           tents in section 1 of the Employee Retirement In-  
 3           come Security Act of 1974 is amended by inserting  
 4           after the items relating to subpart B of part 7 of  
 5           subtitle B of title I the following new item:

“Sec. 714. Ensuring choice for continuing care.”.

6           (3) EFFECTIVE DATE.—The amendments made  
 7           by this section shall apply with respect to plan years  
 8           beginning on or after January 1, 2001.

9           (b) AMENDMENT TO THE PUBLIC HEALTH SERVICE  
 10          ACT RELATING TO THE GROUP MARKET.—

11           (1) IN GENERAL.—Subpart 2 of part A of title  
 12          XXVII of the Public Health Service Act (42 U.S.C.  
 13          300gg–4 et seq.) is amended by adding at the end  
 14          the following new section:

15          **“SEC. 2707. ENSURING CHOICE FOR CONTINUING CARE.**

16           “(a) IN GENERAL.—With respect to health insurance  
 17          coverage provided to enrollees through a managed care or-  
 18          ganization under a group health plan, or through a health  
 19          insurance issuer providing health insurance coverage in  
 20          connection with a group health plan, such plan or issuer  
 21          may not deny coverage for services provided to such en-  
 22          rollee by a continuing care retirement community, skilled  
 23          nursing facility, or other qualified facility in which the en-  
 24          rollee resided prior to a hospitalization, regardless of  
 25          whether such organization is under contract with such

1 community or facility if the requirements described in sub-  
2 section (b) are met.

3 “(b) REQUIREMENTS.—The requirements of this sub-  
4 section are that—

5 “(1) the service involved is a service for which  
6 the managed care organization involved would be re-  
7 quired to provide or pay for under its contract with  
8 the enrollee if the continuing care retirement com-  
9 munity, skilled nursing facility, or other qualified fa-  
10 cility were under contract with the organization;

11 “(2) the enrollee involved—

12 “(A) resided in the continuing care retire-  
13 ment community, skilled nursing facility, or  
14 other qualified facility prior to being hospital-  
15 ized;

16 “(B) had a contractual or other right to  
17 return to the facility after hospitalization; and

18 “(C) elects to return to the facility after  
19 hospitalization, whether or not the residence of  
20 the enrollee after returning from the hospital is  
21 the same part of the facility in which the bene-  
22 ficiary resided prior to hospitalization;

23 “(3) the continuing care retirement community,  
24 skilled nursing facility, or other qualified facility has

1 the capacity to provide the services the enrollee  
2 needs; and

3 “(4) the continuing care retirement community,  
4 skilled nursing facility, or other qualified facility is  
5 willing to accept substantially similar payment under  
6 the same terms and conditions that apply to simi-  
7 larly situated health care facility providers under  
8 contract with the organization involved.

9 “(c) SERVICES TO PREVENT HOSPITALIZATION.—A  
10 group health plan or health insurance issuer to which this  
11 section applies may not deny payment for a skilled nursing  
12 service provided to an enrollee by a continuing care retire-  
13 ment community, skilled nursing facility, or other quali-  
14 fied facility in which the enrollee resides, without a pre-  
15 ceding hospital stay, regardless of whether the plan or  
16 issuer is under contract with such community or facility,  
17 if—

18 “(1) the plan or issuer has determined that the  
19 service is necessary to prevent the hospitalization of  
20 the enrollee; and

21 “(2) the service to prevent hospitalization is  
22 provided as an additional benefit as described in sec-  
23 tion 417.594 of title 42, Code of Federal Regula-  
24 tions, and would be covered as provided for in sub-  
25 section (b)(1).

1       “(d) RIGHTS OF SPOUSES.—A group health plan or  
2 health insurance issuer to which this section applies shall  
3 not deny payment for services provided by a skilled nurs-  
4 ing facility for the care of an enrollee, regardless of wheth-  
5 er the plan or issuer is under contract with such facility,  
6 if the spouse of the enrollee is already a resident of such  
7 facility and the requirements described in subsection (b)  
8 are met.

9       “(e) EXCEPTIONS.—Subsection (a) shall not apply—  
10       “(1) where the attending acute care provider  
11       and the enrollee (or a designated representative of  
12       the enrollee where the enrollee is physically or men-  
13       tally incapable of making an election under this  
14       paragraph) do not elect to pursue a course of treat-  
15       ment necessitating continuing care; or

16       “(2) unless the community or facility involved—  
17       “(A) meets all applicable licensing and cer-  
18       tification requirements of the State in which it  
19       is located; and

20       “(B) agrees to reimbursement for the care  
21       of the enrollee at a rate similar to the rate ne-  
22       gotiated by the managed care organization with  
23       similar providers of care for similar services.



1       “(f) PROHIBITIONS.—A group health plan and a  
 2 health insurance issuer providing health insurance cov-  
 3 erage in connection with a group health plan may not—

4           “(1) deny to an individual eligibility, or contin-  
 5 ued eligibility, to enroll or to renew coverage with a  
 6 managed care organization under the plan, solely for  
 7 the purpose of avoiding the requirements of this sec-  
 8 tion;

9           “(2) provide monetary payments or rebates to  
 10 enrollees to encourage such enrollees to accept less  
 11 than the minimum protections available under this  
 12 section;

13          “(3) penalize or otherwise reduce or limit the  
 14 reimbursement of an attending physician because  
 15 such physician provided care to an enrollee in ac-  
 16 cordance with this section; or

17          “(4) provide incentives (monetary or otherwise)  
 18 to an attending physician to induce such physician  
 19 to provide care to an enrollee in a manner incon-  
 20 sistent with this section.

21       “(g) RULES OF CONSTRUCTION.—

22          “(1) HMO NOT OFFERING BENEFITS.—This  
 23 section shall not apply with respect to any managed  
 24 care organization under a group health plan, or  
 25 through a health insurance issuer providing health

1 insurance coverage in connection with a group health  
 2 plan, that does not provide benefits for stays in a  
 3 continuing care retirement community, skilled nurs-  
 4 ing facility, or other qualified facility.

5 “(2) COST-SHARING.—Nothing in this section  
 6 shall be construed as preventing a managed care or-  
 7 ganization under a group health plan, or through a  
 8 health insurance issuer providing health insurance  
 9 coverage in connection with a group health plan,  
 10 from imposing deductibles, coinsurance, or other  
 11 cost-sharing in relation to benefits for care in a con-  
 12 tinuing care facility.

13 “(h) PREEMPTION; EXCEPTION FOR HEALTH INSUR-  
 14 ANCE COVERAGE IN CERTAIN STATES.—

15 “(1) IN GENERAL.—The requirements of this  
 16 section shall not apply with respect to health insur-  
 17 ance coverage to the extent that a State law (as de-  
 18 fined in section 2723(d)(1)) applies to such coverage  
 19 and is described in any of the following subpara-  
 20 graphs:

21 “(A) Such State law requires such cov-  
 22 erage to provide for referral to a continuing  
 23 care retirement community, skilled nursing fa-  
 24 cility, or other qualified facility in a manner

1           that is more protective of the enrollee than the  
2           provisions of this section.

3           “(B) Such State law expands the range of  
4           services or facilities covered under this section  
5           and is otherwise more protective of enrollee  
6           rights than the provisions of this section.

7           “(2) CONSTRUCTION.—Section 2723(a)(1) shall  
8           not be construed to provide that any requirement of  
9           this section applies with respect to health insurance  
10          coverage, to the extent that a State law described in  
11          paragraph (1) applies to such coverage.

12          “(i) PENALTIES.—An enrollee may enforce the provi-  
13          sions of this section in an appropriate Federal district  
14          court. An action for injunctive relief or damages may be  
15          commenced on behalf of the enrollee by the enrollee’s legal  
16          representative. The court may award reasonable attorneys’  
17          fees to the prevailing party. If a beneficiary dies before  
18          conclusion of an action under this section, the action may  
19          be maintained by a representative of the enrollee’s estate.

20          “(j) DEFINITIONS.—In this section:

21                 “(1) ATTENDING ACUTE CARE PROVIDER.—The  
22                 term ‘attending acute care provider’ means anyone  
23                 licensed or certified under State law to provide  
24                 health care services who is operating within the

1 scope of such license and who is primarily respon-  
2 sible for the care of the enrollee.

3 “(2) CONTINUING CARE RETIREMENT COMMU-  
4 NITY.—The term ‘continuing care retirement com-  
5 munity’ means an organization that provides or ar-  
6 ranges for the provision of housing and health-re-  
7 lated services to an older person under an agreement  
8 effective for the life of the person or for a specified  
9 period greater than 1 year.

10 “(3) MANAGED CARE ORGANIZATION.—The  
11 term ‘managed care organization’ means an organi-  
12 zation that provides comprehensive health services to  
13 enrollees, directly or under contract or other agree-  
14 ment, on a prepayment basis to such individuals.  
15 For purposes of this section, the following shall be  
16 considered as managed care organizations:

17 “(A) A Medicare+Choice plan authorized  
18 under section 1851(a) of the Social Security  
19 Act (42 U.S.C. 1395w–21(a)).

20 “(B) Any other entity that manages the  
21 cost, utilization, and delivery of health care  
22 through the use of predetermined periodic pay-  
23 ments to health care providers employed by or  
24 under contract or other agreement, directly or  
25 indirectly, with the entity.

1           “(4) OTHER QUALIFIED FACILITY.—The term  
2           ‘other qualified facility’ means any facility that can  
3           provide the services required by the enrollee con-  
4           sistent with State and Federal law.

5           “(5) SKILLED NURSING FACILITY.—The term  
6           ‘skilled nursing facility’ means a facility that meets  
7           the requirements of section 1819 of the Social Secu-  
8           rity Act (42 U.S.C. 1395i–3).”.

9           (2) EFFECTIVE DATE.—The amendment made  
10          by this section shall apply with respect to group  
11          health plans for plan years beginning on or after  
12          January 1, 2001.

13          (c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE  
14          ACT RELATING TO THE INDIVIDUAL MARKET.—

15               (1) IN GENERAL.—The first subpart 3 of part  
16          B of title XXVII of the Public Health Service Act  
17          (42 U.S.C. 300gg–51 et seq.) (relating to other re-  
18          quirements) is amended—

19                       (A) by redesignating such subpart as sub-  
20                       part 2; and

21                       (B) by adding at the end the following new  
22                       section:

23          **“SEC. 2753. ENSURING CHOICE FOR CONTINUING CARE.**

24               “The provisions of section 2707 shall apply to health  
25          maintenance organization coverage offered by a health in-

1 surance issuer in the individual market in the same man-  
2 ner as they apply to such coverage offered by a health  
3 insurance issuer in connection with a group health plan  
4 in the small or large group market.”.

5 (2) EFFECTIVE DATE.—The amendment made  
6 by this section shall apply with respect to health in-  
7 surance coverage offered, sold, issued, renewed, in  
8 effect, or operated in the individual market on or  
9 after January 1, 2001.

10 **SEC. 805. GRANTS TO DEVELOP AND ESTABLISH REAL**  
11 **CHOICE SYSTEMS CHANGE INITIATIVES.**

12 (a) ESTABLISHMENT.—

13 (1) IN GENERAL.—The Secretary of Health and  
14 Human Services (in this section referred to as the  
15 “Secretary”) shall award grants described in sub-  
16 section (b) to States to support real choice systems  
17 change initiatives that establish specific action steps  
18 and specific timetables to achieve enduring system  
19 improvements and to provide consumer-responsive  
20 long-term services and supports to eligible individ-  
21 uals in the most integrated setting appropriate based  
22 on the unique strengths and needs of the individual,  
23 the priorities and concerns of the individual (or, as  
24 appropriate, the individual’s representative), and the

1 individual's desires with regard to participation in  
2 community life.

3 (2) ELIGIBILITY.—To be eligible for a grant  
4 under this section, a State shall—

5 (A) establish a Consumer Task Force in  
6 accordance with subsection (d); and

7 (B) submit an application at such time, in  
8 such manner, and containing such information  
9 as the Secretary may determine. The applica-  
10 tion shall be jointly developed and signed by the  
11 designated State official and the chairperson of  
12 such Task Force, acting on behalf of and at the  
13 direction of the Task Force.

14 (3) DEFINITION OF STATE.—In this section,  
15 the term “State” means each of the 50 States, the  
16 District of Columbia, Puerto Rico, Guam, the  
17 United States Virgin Islands, American Samoa, and  
18 the Commonwealth of the Northern Mariana Is-  
19 lands.

20 (b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE  
21 INITIATIVES.—

22 (1) IN GENERAL.—From funds appropriated  
23 under subsection (f), the Secretary shall award  
24 grants to States to—

1 (A) support the establishment, implemen-  
2 tation, and operation of the State real choice  
3 systems change initiatives described in sub-  
4 section (a); and

5 (B) conduct outreach campaigns regarding  
6 the existence of such initiatives.

7 (2) DETERMINATION OF AWARDS; STATE AL-  
8 LOTMENTS.—The Secretary shall develop a formula  
9 for the distribution of funds to States for each fiscal  
10 year under subsection (a). Such formula shall give  
11 preference to States that have a higher need for as-  
12 sistance, as determined by the Secretary, based on  
13 indicators such as a relatively higher proportion of  
14 long-term services and supports furnished to individ-  
15 uals in an institutional setting but who have a plan  
16 described in an application submitted under sub-  
17 section (a)(2).

18 (c) AUTHORIZED ACTIVITIES.—A State that receives  
19 a grant under this section shall use the funds made avail-  
20 able through the grant to accomplish the purposes de-  
21 scribed in subsection (a) and, in accomplishing such pur-  
22 poses, may carry out any of the following systems change  
23 activities:

24 (1) NEEDS ASSESSMENT AND DATA GATH-  
25 ERING.—The State may use funds to conduct a



1 statewide needs assessment that may be based on  
2 data in existence on the date on which the assess-  
3 ment is initiated and may include information about  
4 the number of individuals within the State who are  
5 receiving long-term services and supports in unnec-  
6 essarily segregated settings, the nature and extent to  
7 which current programs respond to the preferences  
8 of individuals with disabilities to receive services in  
9 home and community-based settings as well as in in-  
10 stitutional settings, and the expected change in de-  
11 mand for services provided in home and community  
12 settings as well as institutional settings.

13 (2) INSTITUTIONAL BIAS: REMEDIES AND PRO-  
14 MOTION OF COMMUNITY PARTICIPATION.—The State  
15 may use funds to identify, develop, and implement  
16 strategies for modifying policies, practices, and pro-  
17 cedures that unnecessarily bias the provision of long-  
18 term services and supports toward institutional set-  
19 tings and away from home and community-based  
20 settings, including policies, practices, and procedures  
21 governing statewideness, comparability in amount,  
22 duration, and scope of services, financial eligibility,  
23 individualized functional assessments and screenings  
24 (including individual and family involvement), knowl-  
25 edge about service options, and promotion of self-di-

1 rection of services and community-integrated living  
2 and service arrangements that facilitate participa-  
3 tion in community life to the fullest extent possible  
4 and desired by the individual.

5 (3) OVER MEDICALIZATION OF SERVICES.—The  
6 State may use funds to identify, develop, and imple-  
7 ment strategies for modifying policies, practices, and  
8 procedures that unnecessarily bias the provision of  
9 long-term services and supports by health care pro-  
10 fessionals to the extent that quality services and  
11 supports can be provided by other qualified individ-  
12 uals, including policies, practices, and procedures  
13 governing service authorization, case management,  
14 and service coordination, service delivery options,  
15 quality controls, and supervision and training.

16 (4) INTERAGENCY COORDINATION; SINGLE  
17 POINT OF ENTRY.—The State may support activities  
18 to identify and coordinate Federal and State poli-  
19 cies, resources, and services, relating to the provision  
20 of long-term services and supports, including the  
21 convening of interagency work groups and the enter-  
22 ing into of interagency agreements that provide for  
23 a single point of entry with one-stop access for long-  
24 term support services and the design and implemen-  
25 tation of a coordinated screening and assessment

1 system for all persons eligible for long-term services  
2 and supports.

3 (5) TRAINING AND TECHNICAL ASSISTANCE.—

4 The State may carry out directly, or may provide  
5 support to a public or private entity to carry out  
6 training and technical assistance activities that are  
7 provided for individuals with disabilities, and, as ap-  
8 propriate, their representatives, attendants, and  
9 other personnel (including professionals, paraprofes-  
10 sionals, volunteers, and other members of the com-  
11 munity).

12 (6) PUBLIC AWARENESS.—The State may sup-  
13 port a public awareness program that is designed to  
14 provide information relating to the availability of  
15 choices available to individuals with disabilities for  
16 receiving long-term services and support in the most  
17 integrated setting appropriate.

18 (7) TRANSITIONAL COSTS.—The State may use  
19 funds to provide transitional costs such as rent and  
20 utility deposits, first month's rent and utilities, bed-  
21 ding, basic kitchen supplies, and other necessities re-  
22 quired for an individual to make the transition from  
23 an institutional facility to a community-based home  
24 setting where the individual resides.

1           (8) TASK FORCE.—The State may use funds to  
2       support the operation of the Consumer Task Force  
3       established under subsection (d).

4           (9) DEMONSTRATIONS OF NEW APPROACHES.—  
5       The State may use funds to conduct, on a time-lim-  
6       ited basis, the demonstration of new approaches to  
7       accomplishing the purposes described in subsection  
8       (a)(1).

9           (10) IMPROVEMENT IN THE QUALITY OF SERV-  
10      ICES AND SUPPORTS.—The State may use funds to  
11      improve the quality of services and supports pro-  
12      vided to individuals with disabilities and their fami-  
13      lies.

14          (11) OTHER ACTIVITIES.—The State may use  
15      funds for any systems change activities that are not  
16      described in any of the preceding paragraphs of this  
17      subsection and that are necessary for developing, im-  
18      plementing, or evaluating the comprehensive state-  
19      wide system of community-integrated long-term serv-  
20      ices and supports.

21      (d) CONSUMER TASK FORCE.—

22          (1) ESTABLISHMENT AND DUTIES.—To be eli-  
23      gible to receive a grant under this section, each  
24      State shall establish a Consumer Task Force (re-  
25      ferred to in this section as the “Task Force”) to as-

1       sist the State in the development, implementation,  
2       and evaluation of real choice systems change initia-  
3       tives.

4           (2) APPOINTMENT.—Members of the Task  
5       Force shall be appointed by the Chief Executive Of-  
6       ficer of the State in accordance with the require-  
7       ments of paragraph (3), after the solicitation of rec-  
8       ommendations from representatives of organizations  
9       representing a broad range of individuals with dis-  
10      abilities and organizations interested in individuals  
11      with disabilities.

12           (3) COMPOSITION.—

13           (A) IN GENERAL.—The Task Force shall  
14       represent a broad range of individuals with dis-  
15       abilities from diverse backgrounds and shall in-  
16       clude representatives from Developmental Dis-  
17       abilities Councils, Mental Health Councils,  
18       State Independent Living Centers and Councils,  
19       Commissions on Aging, organizations that pro-  
20       vide services to individuals with disabilities and  
21       consumers of long-term services and supports.

22           (B) INDIVIDUALS WITH DISABILITIES.—A  
23       majority of the members of the Task Force  
24       shall be individuals with disabilities or the rep-  
25       resentatives of such individuals.

1 (C) LIMITATION.—The Task Force shall  
2 not include employees of any State agency pro-  
3 viding services to individuals with disabilities  
4 other than employees of agencies described in  
5 the Developmental Disabilities Assistance and  
6 Bill of Rights Act (42 U.S.C. 6000 et seq.) or  
7 the Protection and Advocacy for Mentally Ill  
8 Individuals Act of 1986 (42 U.S.C. 10801 et  
9 seq.).

10 (e) AVAILABILITY OF FUNDS.—

11 (1) FUNDS ALLOTTED TO STATES.—Funds al-  
12 lotted to a State under a grant made under this sec-  
13 tion for a fiscal year shall remain available until ex-  
14 pended.

15 (2) FUNDS NOT ALLOTTED TO STATES.—Funds  
16 not allotted to States in the fiscal year for which  
17 they are appropriated shall remain available in suc-  
18 ceeding fiscal years for allotment by the Secretary  
19 using the allotment formula established by the Sec-  
20 retary under subsection (b)(2).

21 (f) ANNUAL REPORT.—A State that receives a grant  
22 under this section shall submit an annual report to the  
23 Secretary on the use of funds provided under the grant.  
24 Each report shall include the number and percentage in-  
25 crease in the number of eligible individuals in the State

1 who receive long-term services and supports in the most  
2 integrated setting appropriate, including through commu-  
3 nity attendant services and supports and other commu-  
4 nity-based settings.

5 (g) FUNDING.—

6 (1) FISCAL YEAR 2001.—For the purpose of  
7 making grants under this section, there are appro-  
8 priated, out of any funds in the Treasury not other-  
9 wise appropriated, \$50,000,000 for fiscal year 2001.

10 (2) FISCAL YEAR 2002 AND THEREAFTER.—

11 There is authorized to be appropriated such sums as  
12 may be necessary to carry out this section for fiscal  
13 year 2002 and each fiscal year thereafter.

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